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JANUARY 1980  
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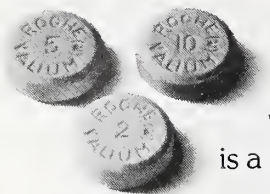
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**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

**Usage in Pregnancy:** Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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**Our Cover**

A rebel from New England, W. Herbert Dunton, born in Augusta, Maine, August 28, 1878, became one of the principal sources for Easterners wanting to know what the West was like. His painting, "The Shower," on our cover captures Western dimensions in its immense, torrential sky. Like Turner, "Buck" Dunton submitted himself to the West in all its flighty weathers. A Taos painter until his death in 1936, Dunton did his bit to "hand down to posterity a bit of the unadulterated real thing." Credit: The Anschutz Collection.

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Editorial and Business Office  
1601 E. 19th Ave.  
Denver, Colorado 80218  
Telephone (303) 861-1221

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Young, Assistant Editor

Ownership and Sponsorship: *Colorado Medicine* (ISSN 0035-760X) is published by the Colorado Medical Society and is published monthly as a not-for-profit enterprise for the mutual benefit of the organizations which jointly sponsor it. It is published under the direction of the Board of Trustees of the Colorado Medical Society. It is the Official Journal of the Colorado Medical Society and the Rocky Mountain Medical Conference.

Advertising: National representative: John H. Harling, Inc., 8 South Michigan Avenue, Chicago, Illinois, 60603. Telephone: (312) 641-9755.

Subscriptions: \$12.00 per year in advance, postpaid in the United States and its possessions; single copy \$1.25 including postage. Subscription is included in medical society dues of the Colorado Medical Society.

Second class postage paid at Denver, Colorado

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## president's letter

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After having attended the American Medical Association Interim Session the first week of December, I am pleased to report that, as usual, your Delegates (Bob McCurdy and Kenneth Platt) and Alternates (Joe Kovarik and Bill Takahashi) performed admirably in Reference Committees and on the floor of the House. These four physicians have an outstanding voice in AMA activities.



I would wish that every physician in this state could witness an AMA House of Delegates meeting. The color, drama and debate of the issues germane to our daily activities is an impressive process to witness. One cannot help but be caught up in the intensity of debate.

There is, I think, a widespread belief that the AMA is an organization that is unyielding, behind the times and deaf to the voice of the physician's causes. Not so! There is a healthy balance between our AMA Board of Trustees, the House of Delegates and the Councils. Debate on the floor of the House is manifested through excellent parliamentary guidance and delegates with outstanding ability to express themselves. Regional and state interests are demonstrated with a single goal in mind: the welfare of our

patients. The question in the democratic process of the AMA is, and always must be, how to approach that goal. I repeat: the AMA is doing a good job in representing the physicians of America. The AMA deserves your fullest support.

1980 is upon us; another decade to predict, so I'll make some predictions. I believe we will see the end of some dread diseases this next ten years. I'm speaking of breakthroughs on the level of an end to smallpox, poliomyelitis and an isolated group of malignancies. Certainly, immunology technics, which are near perfection, will wipe out many diseases.

I also predict the development of communications processes which will create new avenues of training, consultation and transport. Without question, such advancements will change patterns of practice.

It is my prediction that serious debate will occur, focusing attention on the new science of genetic change and development. Of course no conclusion can be drawn now; however, we will surely realize capabilities of predicting and making changes in life forms. These developments will create intense moral differences of opinion.

I believe we will, therefore, be more involved than ever in preventive aspects of medicine and, thus, attempt to redefine "preventive."

In any event the decade of the '80s will bring numerous new problems combined with great homes, the very meat of our existence.

Happy New Year to you and yours!

*Ray S. Witzman*

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## executive report

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In this and future issues of *Colorado Medicine* we promised some exciting things. Our new format of worthwhile news, interesting articles, controversial topics and scientific briefs hopefully will entice you to put *Colorado Medicine* on top of your reading list. Please let us know your opinions and suggestions. We sincerely want to "meet your needs".

In the short time that I have been aboard as Executive Vice President of your Medical Society and Foundation, I have been amazed with the variety of issues in which your Society and FMC has been involved. Major governmental issues to be faced early in January are the Medically Indigent, Nurse Practitioners and the Colorado Hospital Commission. Your Hartford malpractice program and its 1980 rates will also be reviewed and renegotiated soon.

I have met with the executive staffs of many other health related organizations and they are anxious to continue close ties with CMS and CFMC in order to develop a "team" approach to



identify issues concerning us. It seems easy to identify problems facing medicine but concrete solutions or specific goals are very illusive.

Our internal organizations are also hard at work: (1) The executive staffs of the Medical Society and FMC are meeting jointly to develop an internal structure, communications and staff priorities, so that the organizations can accomplish their common goals but each in their distinct way. (2) The Foundation is exploring ways to provide a variety of needed services to physicians, hospitals and patients in the private sector. These activities would therefore be separate from their excellent but government supported PSRO activities. (3) Communications and public information services for the Medical Society and Foundation are being greatly expanded. Much more information will be available to you, your specialty society, and your component medical societies.

Dr. Witham, President of CMS, is spending a great deal of time visiting component medical societies. I am also available to any component society. (4) The Specialty Societies Office of the Medical Society has a new director, Ms. Vi

Brown. Call her for information or services. (5) The CMS role in legislative areas is becoming more and more important. Because of increasing commitment to good health legislation and Mrs. Carol Tempest's superb track record as our lobbyist, she will now head our legislative activities for the Medical Society and the Foundation.

These are just a glimpse of some of our early 1980 Medical Society and Foundation activities. However, rather than trying to be "all things to all people" there is order. In addition to the staff activities mentioned above, the President and the Executive Committee of the Board are also addressing major issues for 1980 with other members of the CMS leadership. These efforts all lead to — the 1980 Winter Clinics. This year's Interim Session on February 29-March 2 at Writers Manor should offer something for everyone. The Scientific Program is as practical as it is excellent. In addition, the Reference Committees of the House will meet to give the officers and staff the direction needed for the balance of 1980. I would hope you would participate enthusiastically.



## FREE TO CHOOSE

The Colorado Association of Commerce and Industry has announced a series of television programs on Capitalism, dealing with economics and the benefits of a capitalistic society. This PBS television series features Milton Friedman, Nobel laureate, economist, and columnist, in which he "challenges us with startling facts and thought-provoking ideas, then responds to opposing views, raising brass-tack questions about the future of our society."

The series of ten programs will air on KRMA-TV, Channel 6, Denver, at the following times:

**Power of the Market** - 9 p.m., Friday, January 11, 1980

12 noon, Saturday, January 12, 1980

**The Tyranny of Control** - 9 p.m., Friday, January 18, 1980

12 noon, Saturday, January 19, 1980

**Anatomy of Crisis** - 9 p.m., Friday, January 25, 1980

12 noon, Saturday, January 26, 1980

**From Cradle to Grave** - 9 p.m., Friday, February 1, 1980

12 noon, Saturday, February 2, 1980

**Created Equal** - 9 p.m., Friday, February 8, 1980

12 noon, Saturday, February 9, 1980

**What's Wrong With Our Schools?** - 9 p.m., Friday, February 15, 1980

12 noon, Saturday, February 16, 1980

**Who Protects the Consumer?** - 9 p.m., Friday, February 22, 1980

12 noon, Saturday, February 23, 1980

**Who Protects the Worker?** - 9 p.m., Friday, February 29, 1980

12 noon, Saturday, March 1, 1980

**How to Cure Inflation** - 9 p.m., Friday, March 7, 1980

12 noon, Saturday, March 8, 1980

**How to Stay Free** - 9 p.m., Friday, March 14, 1980

12 noon, Saturday, March 15, 1980

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# council on legislation

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As the new year begins, so does another session of the Colorado General Assembly. With the call to order of this short session the Colorado Medical Society's Council on Legislation focuses its attention on the health matters before the legislature.

The lobbyist, staff and Council members are closely monitoring developments in the nurse practice controversy, problems of the medically indigent and the pros and cons of extending the hospital commission. They're also watching items of national interest, such as a national health insurance plan and Federal Trade Commission regulations.

During early December, Phil Milstein and Craig Barnes, Colorado Hospital Commissioners, met with the Councils on Legislation and Socio-Economics to present their reasons for requesting that the Commission be extended for at least one more year. The Councils will meet on January 9, 1980, to hear the positions of the Colorado Hospital Association and Blue Cross/Blue Shield.

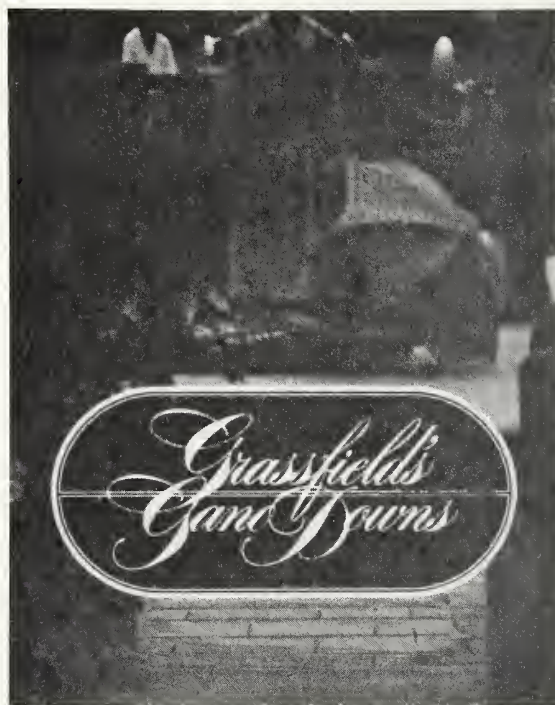
The Colorado Board of Medical Examiners will hold a hearing on January 10, 1980, concerning the proposed rules and regulations. These rules and regulations were presented to the Council for Interprofessional Relations by Brian Stutheit, Director of the Division of Interprofessional Relations. Recommendations of that Council will present recommendations to the Council on Legislation prior to the Board of Medical Examiner's January meeting.

The Council on Legislation voted to again sponsor a legislative seminar at the close of the 1980 session, May 30, 31, and June 1. The seminar will be held at The Lodge at Vail. Colorado Medical Society members will be kept apprised of program developments as they occur.

The Chairman of the Council on Legislation has written the Public Policy Chairmen of each component society as well as to specialty society presidents, urging support of the KeyMan program.

Jack Warren, MD, Chairman

## Sale Time Quality Clothing At Substantial Savings



At Grassfield's Gano-Downs, January is devoted to selectively reducing the price of our inventory in preparation for a new season. A sale at Grassfield's means a reduction of our regular first quality inventory. Our annual clearance sale is now in progress. You will find reduced prices at all three Grassfield locations.

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**Editor's Note:** With this issue of the new *Colorado Medicine* we hope in this "department" to accord medical specialists a direct communication channel from their box seats (even if only spectators) to the participants in the arena of gladiatorial melee below encompassing organized medicine in general. Attendees at AMA or component medical society houses of delegates can testify from the cacophony and adversarial debates that medical democracy comes in noisy and inefficient modalities. Often democracy's crystallized actions ooze out of fog and delay, aggravatingly behind those of the specialized medical fraternities with their more sharply focussed objectives and responsibilities. Yet clearly, generalists and proliferating specialists need effective liaison rapport with each other if the physician's professionalism is to survive amid strident attacks from those who would usurp authority (but never the clinical responsibility), who would dictate expediency in the name of cost-containment or political largesse. May we here serve to bring the specialties closer to each other and under the umbrella of AMA and organized medicine.

In this issue we've asked our psychiatrist colleagues to report on some creative activism they've undertaken on their own:

### **Colorado Psychiatric Society: OUTREACH RESOURCE PROJECT**

True to their vaunted psychodynamic perspective, CPS psychiatrists have worried about their "image" out-state, among citizenry and professional colleagues alike. Sam Wagonfeld, MD, our legislative chairman, perceived problems in sharp relief as dialog occurred (or didn't) with state legislators during the last Assembly. Patently, policy-generators and state lawmakers hear of psychiatry only during state Assemblies, and then often from lobbyists in reactionary posture, in a climate straight-jacketed by political issues. Sam reasoned that the best psychiatric input would be away from

urban clustering and throughout the year, would reach home-town media and representatives in the context of the psychiatrist's proper role as physician and adviser of helping agencies.

CPS's executive council has approved a pilot project to facilitate and encourage availability of its member psychiatrists for presentations or seminar discussions with local health care groups — by tangibly subsidizing transportation costs of invitees to the community. An inviting group, such as a county medical society, hospital staff, mental health clinic, or mental health association may designate the psychiatrist and subject of its choice, or may request CPS to recruit an appropriate expert for that topic. If desired, CME credit can be sought through the CPS/CMS accreditation mechanism. No honorarium or other perquisite would be expected unless overnight or prolonged stay justifies local hospitality.

Until refined by experience, our present consensus envisions only loose and flexible guidelines:

- Initiative should come from the local (non-profit) group for whom the psychiatrist's input would be helpful, ideally in concert with any local psychiatric colleagues (to avoid any aura of unethical intrusiveness).

- The inviting group and community should feel free to utilize the psychiatrist's availability for additional community or media exposure which would serve public education and understanding — e.g. staff conferences with clinic or hospital personnel, discussions with public agencies.

- The psychiatrist's dominant commitment will be to communicate responsively and practically in addressing the community's needs and concerns — irrespective of his own parochial "school" or accustomed jargon.

- Requests should be directed more than a month in advance to the society's executive secretary, Mrs. Jeannette Currier, 1555 East Lake Place, Littleton, Colo., 80121 (Tel. 795-8404). They should designate the preferred speaker(s), topic, date, time required, and anticipated audience focus for both primary function and any subsequent roles during the visit.

In sum, the psychiatric society seeks to catalyze useful and practical out-reach psychiatric education and counselling — remote from academic and urban “meeting-out” milieus — by implementing the availability and transportation of its otherwise shy and non-assertive experts, and by encouraging smaller out-state groups to request these re-

source appearances where helpful. Should psychiatrists encounter a few local problems, media, and legislators on home ground, we’ll all learn and Sam’s creativity will have been validated.

Clyde Stanfield, MD  
CPS Public Affairs Representative

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## the lobby

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The medical indigency issue continued to dominate your lobbyist’s December. With the possibility that I may be a member of that indigent group when Christmas bills have been paid, I have been working hard with every possible interest group to find a solution that is rational, financially feasible, and sellable to the legislature.

Having been assured that the governor would include a health insurance title in his “call”, we were suddenly alerted a week before Christmas that he was wavering and was being urged by some members of his cabinet not to include it. One argument being used is that a health insurance bill would reap windfall profits for physicians and hospitals.

As the Department of Health’s conceptualization of health insurance for the medically indigent has become more widely dispersed, new approaches are surfacing. Furthest along is one by Representative John McElderry (R), Lakewood, and his chief aide, Dr. Joel Karlin. This concept uses the private insurance industry with competition and business incentives built in. Representative McElderry has sur-

rounded himself with a task force representing a private insurance company, Blue Cross-Blue Shield, Kaiser, senior citizens, hospitals, the former hospital rate review commission, and physicians. We have not been asked to endorse his ideas, but our input seems to be appreciated.

A bill dealing with only catastrophic insurance is being developed by one of the strongest legislators. It will be a very conservative approach but certainly a beginning. The Health Department analysts have indicated dislike for a bill that addresses only catastrophic need, but a conservative legislature may want to go only that far.

At an interesting breakfast meeting hosted by the Denver Medical Society, Representative Carl Gustafson (R), Denver, a much respected fiscal expert in the legislature, warned those present of several interesting facts: hospital care for the indigent helped break New York City, and he won’t let it happen to Denver; a few hospitals and one city aren’t enough of a constituency to pass a medically indigent bill; perhaps DGH should close all but its emergency room and let the other hospitals feel the indigent problem.

Physicians, hospitals, and the middle-class citizen paying the indigents’ medical bills need some help. Let’s hope the title is on the governor’s call, and that some creative thinking produces a good bill.

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On December 18, 1979, Colorado Medical Society, represented by Noel Sankey, MD, presented testimony before the Joint Budget Committee on the issues of Medicaid reimbursement and physician participation.

The Colorado Medical Society supports a \$3 million increase proposed by the Department of Social Services.

In a show of good faith toward the JBC, the Society shall also consider various incentive programs to be developed.

Bruce C. Paton, MD, Denver Colorado, American College of Cardiology Governor for the State of Colorado, announced that the following cardiovascular specialists in his geographic area have achieved the ACC’s membership rank of Fellowship:

Dennis J. Battock, MD, Aurora, Colorado  
Johathan M. Ward, MD, Denver, Colorado



# ChoiceCare in Shutdown

ChoiceCare Health Services of Larimer and Weld Counties in Colorado has shut down operations, according to Ed Petras, Director of the independent practice association. Petras will remain on the job until January 11, 1980, to wind up business matters, but the program is effectively inoperable, as of this publication.

Members of the Board of Directors of Physicians Service Corporation, which represents about 90 per cent of all the physicians practicing in Larimer County, voted December 13 four-to-one against renewing the master contract with ChoiceCare, as of January 1.

ChoiceCare has a reported 26,000 commercial group enrollees, some 2,700 individual members, 6,300 Medicaid and 3,800 Medicare participants, according to the Colorado State Insurance Commissioner's office. ChoiceCare has been described as one of the largest independent practice associations (IPA) in the U.S., and has been in existence for five years, serving the two northern Colorado counties.

Because of the questionable ability of ChoiceCare to reimburse physicians for an estimated \$600,000 to \$1 million in medical services for patients enrolled in the prepaid program, board members of the Physicians Service Corporation voted to discontinue and, possibly, to even forego payment of the fees due because they believe that the HMO concept is not, in the words of John Maloney, MD, President of PSC, "viable for this area." Dr. Maloney told *Colorado Medicine* ChoiceCare proposed a further reduction in hospital utilization, which, in the eyes of the physicians, compromised the quality of health care delivered to the ChoiceCare clients. Dr. Maloney added, "The physicians felt the hospital utilization rate is already low in Larimer County. Any further decrease would compromise the quality of health care delivered, and the physicians felt they could not accept that." Petras, meanwhile, told *Colorado Medicine* "The doctors scuttled a program that provided full medical benefits. I don't know how they would compromise the program. They'd been delivering the health services through this organization for five years." Gary Cole, director of operations for the IPA, in an interview with American Medical News, conceded that

ChoiceCare was experiencing a cash-flow problem and that the IPA/HMO was unable to pay current claims from physicians, but denied that the plan was bankrupt. Cole said "We are trying to put together a package to keep ChoiceCare afloat," adding that the IPA would continue to provide medical services to subscribers while seeking federal assistance to stay in business, and polling primary-care physicians in the county who may wish to participate in the IPA. However, Petras told *Colorado Medicine* that ChoiceCare was "out of business," and that he was remaining on until the mid-January date just to clean up last details.

Petras added "The doctors knew as far back as September that they were not going to be able to borrow any additional money from the Feds because the program was not a qualified HMO. They had already borrowed \$750,000 for the program. The Feds said that if the program were tightened up, if the hospital utilization rate could be brought down, the program could pay out properly for the physicians. Our role was trying to get this thing repositioned as an HMO/IPA. We weren't far away at all. You couldn't do it in a hundred days, but we weren't far away."

Fort Collins physician Steve Thorson, MD, told American Medical News that the IPA ran into financial difficulties because patient claims far exceeded income from premiums, and because too many of the subscribers are high utilizers of medical services. Describing some physicians' "negative emotions" about the floundering IPA, Dr. Thorson said in that same interview, "We feel we have been lied to and deceived. Over the years, we have been deluged with information that HMOs and IPAs were supposed to be the greatest thing since sliced bread." In response to that, Ed Petras told *Colorado Medicine* that "This wasn't an HMO . . . it was a half-baked insurance program." Petras added "I told the Board (of ChoiceCare) that if they could reduce hospital utilization by another 5 per cent in the coming year they (the doctors) would receive 90 per cent of their billing. If they could reduce hospital utilization more than 5 per cent the doctors could expect

100 per cent payment of their fees, and even receive a bonus. They weren't interested in the monetary aspects . . . it was a philosophical difference all the way. In Marion, Ohio, where I came from a similar program, hospital utilization was reduced by 35 per cent. There was no compromise in quality of care. The ChoiceCare board felt that a 5 per cent reduction was possible."

ChoiceCare turned its operations over to the state Insurance Commissioner J. Richard Barnes in December. That same week Barnes announced that the organization was placed under conservatorship. Daniel Colaiannia, Deputy Commissioner, told reporters that this is the first time in the state's history a health-maintenance organization has been taken over by the insurance commissioner's office. ChoiceCare's board of directors believe it had no choice but to turn the agency over to Barnes after participating physicians decided to end their contract with ChoiceCare, board president Peggy Ratliff told Associated Press. Ratliff said the doctors "have philosophical differences with the HMO concept, apparently, and just don't want to budge."

At deadline, Deputy Insurance Commissioner Daniel Colaiannia told *Colorado Medicine* "We're still in a dilemma at this particular time as to the director we're going to go. We have a conservator up there (in Fort Collins at ChoiceCare offices) as you probably well know. He's trying to get it to a point where we can have a general meeting either the 9th or 10th of January to decide our future progress." Colaiannia added that "the way it appears it's

going to go to the courts and a receiver is going to be sought by the Commissioner." Commissioner Colaiannia told *Colorado Medicine* that the conservator is presently working on getting the individual coverages converted. He said that most of the groups have been converted with no problem, but the individual coverage is creating a problem. (At deadline, *Colorado Medicine* learned that Colorado Blue Cross/Blue Shield had taken over coverage for Medicaid and Medicare subscribers in the ChoiceCare program.)

ChoiceCare actually ceased to exist, as of 11:59 p.m., December 31, 1979. Petras reportedly had left the premises as of December 31. Deputy Commissioner Colaiannia said that all decisions pertaining to ChoiceCare are now being made by the Commissioner. The general planning meeting the week of January 7 was to have decided whether the Insurance Commission will go to court to seek a receiver or, as Colaiannia said, to see if there are any other avenues they may be exploring, adding "I don't see any other avenues at this time." He said his personnel do not have the financial information yet to make these decisions. Colaiannia said "They've had computer problems up there, I understand, and half of the information is on the computer and what is on the computer is not available any later than October, I think. It's been a problem, I think, of record keeping and the federal programs have had the same problem of adequate justification of expenditures, and this sort of thing. From what I'm told, there has been a record problem, and we do not have a handle on what the financial position is at this time."

### **Colorado CME Accredited Hospitals Grow in Number**

Aspen Valley Hospital and Otolaryngology specialty society have joined the ranks of organizations accredited for continuing medical education. Aspen Valley Hospital has now become one of 17 rural hospitals accredited for CME, making the continuing medical education available to physicians where they practice. This is by action of the CMS Committee on Accreditation, December 19, 1979. This raises

the total of accredited hospitals in Colorado to 31. The remaining 11 accredited organizations in the state, bringing the total to 42, are specialty societies.

At that same December meeting, six additional hospitals and organizations had their accreditation renewed. One specialty society, the Colorado Otolaryngology and Maxillofacial Society, received new, provisional accreditation during the fourth quarter of 1979 as a result of site visits by members and staff of the Colorado Medical Society.



# Private Initiative in Quality Assurance

A final decision concerning the definition of acceptable hours of continuing medical education was to have been made by the Colorado Board of Medical Examiners at the Board's January 10, 1980, meeting. This decision will be in keeping with the amendment to the Medical Practice Act by the Colorado legislature which removed the requirements of 150 hours of continuing medical education in three years. The new law will require 20 hours of continuing medical education credit acceptable to the Board each year, with no carry-over from year to year, beginning with the 1980 calendar year.

Related to the changes in Colorado's laws is the article, reprinted here from the September, 1979, issue of *Forum on Medicine*, authored by Paul J. Sanazaro, MD, FACPE.

In the perspective of medical history, the 1970s may come to be known as the decade in which public policy concern over medical costs peaked and the wave of continuing medical education crested. In the name of public interest, the federal government extended the interpretation of accountability for expenditure of tax funds to embrace "cost containment" as well as assurance of acceptable professional quality, and 23 state governments mandated continuing medical education as a requirement for registration of licenses.

Until this very decade, the specialty societies had primary responsibility for the quality of care. The primary vehicle of ensuring this quality has been a superb program of continuing education tailored to the unique needs of each specialty. But specialty societies have come to realize the shakiness of the assumptions underlying the rush to mandatory CME by state medical boards in response to public pressure to assure "continuing competence in practice." Looking to the future, representatives of the

American College of Physicians, the American Society of Internal Medicine, and the American Hospital Association decided that the time had come for a major new "private initiative in quality assurance" (PIQuA). Their proposal proved to be of interest to the W.K. Kellogg Foundation, which funded the project in 1978.

The purpose of PIQuA is to determine the feasibility of establishing an ongoing program for the express purpose of devising a mechanism for granting formal recognition of competence to practicing internists. (This is not to be considered a method of eliminating board examinations. Board examinations are cognitive, written examinations, while PIQuA is a program to assess what the physician does and a measurement of how adequately and competently he administers care to the patient.) General policy is set by a joint national committee including two representatives of the general public interest.\*

A pretest of PIQuA took place last year in the San Francisco Bay area with the help of a number of volunteer internists. We compared various methods of collecting performance data and compiled profiles on both their office and hospital practice. From these profiles were drawn samples of patients representative of the most prevalent diagnoses of conditions seen in each practice. These patients' office and hospital records were abstracted in accord with provisional criteria developed by a technical advisory committee and, with the permission and full

\* Official representatives to PIQuA from the sponsoring organizations are William C. Felch, FACP, and Richard J. Bartlett, FACP (ASIM); John R. Gamble, FACP, and Blair Erb, FACP (ACP); and Malcolm D. MacCoun and David A. Reed (AHA). The two representatives from the public are Duncan B. Neuhauser, PhD, an economist with the Harvard School of Public Health, and Lewis H. Butler, an attorney in San Francisco. Dr. Sanazaro is the study director.

Dr. Sanazaro is clinical professor of medicine and ambulatory and community medicine at the University of California, San Francisco, School of Medicine, as well as study director of PIQuA, which has its headquarters in Oakland, California.

cooperation of each internist, a small sample of patients were interviewed by telephone. The joint national committee judged the pretest's results sufficiently encouraging to approve further testing. This will take the form of a field trial conducted in three geographically separate communities.

Ed Miller, MD, Governor for the Colorado Region of the American Colleges of Physicians, described for *Colorado Medicine* the Colorado involvement in this first field trial, which includes Colorado, California and New Jersey:

"In Colorado we're going to examine, wholly on a voluntary basis, the records of a certain number of internists, general internists who work out of mostly Rose Medical Center and St. Luke's Hospital. Both physician and hospital participation is on a purely voluntary basis. It's also wholly confidential so far as the hospital, the physician and the patients are concerned. Neither the patient nor the hospital from which the case originates can be identified. In order not to develop a whole new bureaucracy PIQuA contracts with the hospitals to utilize their auditing professionals, and reimburses the hospitals for the use of those professionals, so that all work is out of the hospitals that are involved. The physicians are recruited to volunteer their records; they are looked at by professional auditors, both the hospital records and the office records. The material is abstracted and sent to the main office for this project, which is in Oakland, California. The material is transferred on to tapes and then is reviewed, again anonymously, by selected general internists (a peer group) in each of the three states, and is evaluated on the basis of criteria established on a national level."

In the interview with *Colorado Medicine*, Dr. Miller was asked what specific goals the PIQuA field test hopes to accomplish: "From this they hope to determine whether the methodology is

practical, is feasible, is cost-effective, and whether it might be applied on a national basis." Dr. Miller added that the study will determine whether this information might not also be used "by third-party carriers, to judge whether a physician is competent or not. It also could be used by state Boards of Examiners who now are being told in many places that they must license on the basis of their perception of the physician's competence."

Dr. Miller was asked if this Private Initiative in Quality Assurance was being urged by third-party carriers or by the state Boards of Medical Examiners. "No! It's entirely a private enterprise thing. It's an attempt on the part of the medical profession to see if this can be done, and can be done without the interjection of government into it." Will there be no government involvement in this field study? "None at all, including no financing."

Dr. Miller pointed out that the PIQuA field study in Colorado was expected to last three to four months, starting some time in January, 1980; however, a definite timetable has not been established. He also noted that, according to the master plan established by the PIQuA headquarters in California, a local group of physicians will be chosen to oversee the study and to assess the findings. "We have selected six general internists that we consider to be very capable and reliable to do the assessment of the abstracts that they're given."

In closing the interview with *Colorado Medicine*, Dr. Miller noted, "There are a lot of internists who have neither taken nor passed the board examinations, but they are certainly competent physicians. The PIQuA method is a way of recognizing their competency. For the pilot project we're only looking at the General Internist; the methodology is applicable across the entire medical field."

CORRECTION: In *Colorado Medicine* for December, 1979, an article described a presentation of medical instruments by Dr. Bernard Sherbok. The presentation was to CARE/MEDICO, and the replacement value of those medical instruments was in excess of \$7,400.



# 9 HEALTH FAIR

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In 1979, more than 190,000 people received some \$20 million in free health screening tests at HEALTH FAIRS held in six cities over a week-long period.

This year, KBTB, Channel 9, will undertake the largest single community service project in its viewing area by sponsoring the 9 HEALTH FAIR April 13-20, 1980.

According to Mrs. Annette Finesilver, Executive Director of the 9 HEALTH FAIR, the HEALTH FAIR concept is the brainchild of Dr. John Brensike of the National Institute of Health who developed the idea in his free time and devotes his vacation each year to organizing HEALTH FAIRS through the non-profit organization, The National Health Screening Council for Volunteer Organizations. In 1980, sixteen cities will hold HEALTH FAIRS.

The major focus of the 9 HEALTH FAIR, Mrs. Finesilver says, will be to provide health screening tests and review and referral of tests at sites throughout the state. Special emphasis will be placed on educating the public as to the ways lifestyle and health habits affect one's health.

Each site, she adds, will offer a minimum of six free screenings including a personal health history, height and weight, visual acuity, blood pressure, anemia and preventive health counseling. Optional tests might include screening for glaucoma, hearing, breast, cervical, oral and colon-rectal cancer, tuberculosis, pulmonary function, ear, nose and throat, podiatry and blood tests (with a minimal charge), syphilis, liver and kidney function, gout and iron content. These tests, she points out, are in no way to be considered replacements for a regular physical examination.

To manage an event of this magnitude, Mrs. Finesilver says, thousands of volunteers are needed.

To that end, Channel 9 held a day-long regional community meeting, November 2 at the Auraria Center where representatives from labor, government, business, non-profit service groups, medical professional organizations, hospitals and clinics were presented with information on the 9 HEALTH FAIR. Dr. Brensike attended the meetings and explained the philosophy and background of the HEALTH

FAIR and the benefits communities could reap by participating.

The response to the 9 HEALTH FAIR, Mrs. Finesilver says, has been overwhelming. To date more than 500 organizations have indicated an interest in being a part of the 9 HEALTH FAIR and some 100 screening sites are anticipated.

Major cooperating organizations include the Colorado Hospital Association which will coordinate the hospitals' activities; the Lions Clubs of Colorado who will provide statewide district coordination, especially in rural areas; the Federal Executive Board and Federal Regional Council which will undertake organization of Federal Government Day for the HEALTH FAIR; and the National Guard which will provide logistical support in storing and moving equipment for the FAIR and provide additional medical volunteers.

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Currently the 9 HEALTH FAIR schedule breaks out as follows:

**Sunday, April 13. Hospital Day.** The Colorado Hospital Association will set up screening sites at 40 to 50 hospitals statewide, including V.A. hospitals in Denver, Grand Junction and Ft. Lyon.

**Monday, April 14 and Tuesday, April 15. Major employers Day.** Some 20-30 major employers are expected to participate and on Tuesday, Federal Government Day, the goal will be to screen 5,000 federal employees.

**Wednesday, April 16. Older Americans' Day.** Sponsors will include the Volunteers of America, Central Bank of Denver, Denver Regional Council on Governments and the Office on Aging, State of Colorado.

**Thursday, April 17. Community Day.** Screening for community residents at schools, churches, senior centers, businesses and recreation centers across the state.

**Friday, April 18, Saturday, April 19, Sunday, April 20. Shopping Malls Days.** Five major

shopping malls to date have committed to sponsoring sites for screenings which should draw several thousand people.

While non-medical volunteers are vital to the success of this event in terms of registering participants, taking medical histories, handling followup and sponsoring sites, the involvement of the medical community is critical to the quality of screening and counseling offered.

Mrs. Finesilver envisions the role of physicians and allied health professionals as playing important parts in four phases of this event: pre-planning, pre-event, HEALTH FAIR week and post HEALTH FAIR followup.

In the pre-planning stages, physicians and health professionals will be needed, she says, to counsel staff regarding acceptable medical practices in Colorado. The Medical Society is invited to review all testing procedures to ensure credibility and acceptance by Colorado physicians.

## 9HEALTH FAIR

Another possibility, Mrs. Finesilver adds, would be for the Medical Society to act as a pre-event sponsor by holding a televised model HEALTH FAIR which would focus attention on the upcoming event. A tie-in for this could be the Olympics, emphasizing in the program the necessity of exercise to physical fitness and benefits of proper nutrition.

During HEALTH FAIR week, individuals could volunteer to perform tests such as foot and back screening, glaucoma screening, oral, rectal and cervical cancer screenings as well as serving as backup at a counseling station for complicated cases.

After the FAIR, health professionals could assist with followups. For example organizing meetings where the significance of various tests would be explained in lay persons' language.

In addition an especially significant contribution would be help by nurses, health educators and paramedics with the Health Hazard Appraisal followup. These appraisals will be offered by the Center for Disease Control to cities that can provide followup educational sessions involving one-to-one counseling. At this point, Mrs. Finesilver says, the Health Hazard Appraisal will only be available to Colorado if sufficient medical professionals volunteer to coordinate it.

Additional support might include educa-

## 9HEALTH FAIR

tional seminars such as stop smoking sessions, cardiovascular fitness, diet and diabetes education sessions.

Some extremely interesting data has come out of studies from last year's HEALTH FAIRS, Mrs. Finesilver notes. Statistics indicate that:

Approximately 30% of the participants were over the age of 60, 10% were under the age of 30 and the remaining 60% were in the 30 to 60 age range.

Approximately 15% of the participants were classified as indigent, another 15% as "medically indigent", i.e. persons with income above the poverty level, but unable to afford anything other than emergency medical care.

Approximately 47% of the participants provided the names of a primary source of care to send copies of their test results to.

34% indicated that they had seen a physician for a non-illness visit in the last year, 24% in the last 1-2 years and 42% in over 2 years.

Random calls were made to 1,000 participants in the Washington, D.C. metropolitan area asking "when was the last time that you had all of the tests offered at the HEALTH FAIR as part of a check up when you were not sick?" The sampling revealed that 63.8% had never had all of the tests offered at the HEALTH FAIR as part of a previous check up when they had not been sick.

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From this information, the National Health Screening Council formulates that the average participant, if there is such a person, is a 30 to 60 year-old middle class person who generally feels well, who could afford a preventive medical program but whose insurance does not cover it, and whose priorities do not establish health promotion and early detection at a high enough level to have them spend monies to obtain such care.

Currently, Mrs. Finesilver says, the Federal Government indicates that large numbers of people have no sources of medical care in their communities but that physicians state that for all persons seeking care, a source can be found.

She invites commitment from the medical community to support and endorse this unique source of preventive health care, the 9 HEALTH FAIR.



# CONTINUING MEDICAL EDUCATION CALENDAR

PUBLISHED JOINTLY BY THE COLORADO FOUNDATION FOR MEDICAL CARE, COLORADO MEDICAL SOCIETY AND THE COLORADO ACADEMY OF FAMILY PHYSICIANS • 1601 EAST NINETEENTH AVENUE, DENVER, COLORADO 80218

## FEBRUARY 1980

### 8th-9th

**WELLNESS, A GOAL TOWARD OPTIMUM HEALTH.** St. Mary's Hospital and Medical Center, Grand Junction, Colorado. Contact: Patrick G. Moran, MD, Continuing Medical Education, St. Mary's Hospital and Medical Center, P.O. Box 1628, Grand Junction, Colorado 81501.

### 13th-16th

**NINETEENTH ANNUAL JOHN R. DURRANCE MID-WINTER CHEST CONFERENCE.** Aspen Institute for Humanistic Studies and the Aspen Meadows. Contact: Dallis Pierson, American Lung Association, 1600 Race Street, Denver, CO 80206. 388-4327. (10 hours of AMA Category 1 credit).

## MARCH 1980

### 5th

**MY PARENT THE SHRINK.** University of Colorado Medical Center, Room 2K08, Denver. Contact: Colorado Child and Adolescent Society, 1601 E. 19th Ave., Denver, CO 80218. 861-1221, ext. 241. (2 hours of AMA Category 1 credit).

### 5th

**NEUROPSYCHIATRIC GRAND ROUNDS.** Colorado State Hospital, Pueblo. Contact: Jay Scully, M.D., 1600 W. 24th St., Pueblo, CO 81003. 543-1170.

### 8th

**SURVIVAL AND CREATIVITY.** Fairmont Hotel, Denver. Contact: Mt. Airy Psychiatric Center, 4455 E. 12th Ave., Denver, CO 80220. 322-1803. (6 hours of AMA Category 1 credit).

### 9th

**SYMPOSIUM ON ALCOHOLISM.** Writer's Manor, Denver. Contact: National Council on Alcoholism, 2525 W. Alameda Ave., No. 214, Denver, CO 80219. (8 hours of AMA Category 1 credit).

### 15th-22nd

**RECOGNITION AND MANAGEMENT OF THE STROKE PRONE PATIENT.** The Mark, Vail, CO. Contact Faith Carlisi, College of Medicine, Health Sciences Center, Tucson, Arizona 85724.

### 21st

**INFECTIOUS DISEASE.** Denison Auditorium, University of Colorado Medical Center, Denver. Contact: Office of Postgraduate Medical Education, University of Colorado Medical Center, 4200 E. 9th Ave., Denver, CO 80262. 394-5241.

## APRIL 1980

### 2nd

**CHILDHOOD DEPRESSION.** University of Colorado Medical Center, Room 2K08, Denver. Contact: Colorado Child and Adolescent Society, 1601 E. 19th Ave., Denver, CO 80218. 861-1221, ext. 241. (2 hours of AMA Category 1 credit).

### 8th

**CURRENT APPROACHES TO PSYCHIATRIC EDUCATION FOR MEDICAL STUDENTS.** Bethesda Hospital, Denver. Contact: Bethesda Hospital, 4400 E. Iliff Ave., Denver, CO 80222. 758-1514. (1 hour of AMA Category 1 credit).

### 11th

**CHILDREN'S ORTHOPAEDIC DAY.** Children's Hospital, Denver. Contact: Robert E. Eilert, M.D., Children's Hospital, 1056 E. 19th Ave., Denver, CO 80218. 861-6600. (AMA Category 1 credit approved; AAFP credit applied for).

### 11th

**DERMATOLOGY.** Denison Auditorium, University of Colorado Medical Center. Contact: Office of Postgraduate Medical Education, University of Colorado Medical Center, 4200 E. 9th Ave., Denver, CO 80262. 394-5241.

### 14th-15th

**A DEVELOPMENTAL APPROACH TO TREATMENT OF THE FAMILY.** Boulder Psychiatric Institute. Contact: Boulder Psychiatric Institute, P.O. Box 3497, Boulder, CO 80307. 447-2902. (2 hours of AMA Category 1 credit).

### 17th-20th

**LOW FLOW AND CLOSED CIRCUIT ANESTHESIA.** Denver. Contact: Office of Postgraduate Medical Education, University of Colorado Medical Center, 4200 E. 9th Ave., Denver, CO 80262. 394-5241.

### 23rd

**SOFT TISSUE CLOSURE WITH SKIN FLAPS.** Julesburg, CO. Contact: Martin J. Rubinowitz, M.D., The Denver Clinic, 701 E. Colfax Ave., Denver, CO 80203. (2 hours of AMA Category 1 credit; 2 prescribed hours of AAFP credit).

### 27th-May 3rd

**CLINICAL MANAGEMENT AND CONTROL OF TUBERCULOSIS.** National Jewish Hospital. Contact: Paul T. Davidson, M.D., Chief, Tuberculosis & Chest Section; Department of Medicine, National Jewish Hospital, 3800 E. Colfax Ave., Denver, CO 80206. 388-4461.

# Bipartite carpal navicular

## Case Report and Discussion\*

Bernard C. Sherbok, MD, and John M. Grogan, MD

*Bipartite carpal navicular is a rare and little known congenital anomaly. There is a difference of opinion whether or not this is to be considered a definite entity or a non-union of a fracture. The authors conclude that bipartite carpal navicular is a distinct clinical entity.*

Bipartite carpal navicular is an uncommon or rare congenital anomaly which is given either scant attention in many standard orthopaedic and roentgenographic textbooks, or is not mentioned at all in others. For this reason it is generally unknown and very frequently misdiagnosed as an ununited fracture. A correct diagnosis is essential for the following very important reasons:

1. A mistaken diagnosis leads to unnecessary prolongation of immobilization of the wrist with the probability of residual limitation of motion.
2. Unnecessary surgery may be performed.
3. Accurate recognition of the condition in compensation cases where an injury is involved is obvious. The rarity of this anomaly and the incorrect diagnosis in a compensation case encountered by the authors merit the reporting and review of this condition.

## CASE REPORT

The patient, J.B. age 48, had no previous injury to either wrist. On November 2, 1976, while employed as an assistant beauty operator, she was involved in an altercation with another female employee who grabbed her hands, squeezed them and then shook her wrists. This procedure was repeated a second time during which, the patient stated, she "heard something snap" in her right wrist. She experienced immediate pain in both wrists, more marked on the right. Shortly afterward she tried to work on a patron but was unable to do so. She went home at which time she claimed both wrists were "red and swollen".

Because the patient thought that the pain would subside spontaneously, she did not seek medical aid until November 4th when, after the clinical and roentgenographic examinations, a diagnosis of fracture of the carpal navicular of the right wrist was made and a long arm cast was applied. There were no specific recommendations concerning the left wrist. On January 6, 1977 the long arm cast was replaced by a forearm cast which was worn until mid April when a removable plastic volar splint was prescribed and used on occasion to the time she was examined by the authors. The attending Doctor's last report dated August 4, 1977 to the State Compensation Insurance Fund stated in part: "Today x-rays showed poor healing of the wrist fracture with osteoporosis on both sides of the fracture site. . . . It is impossible to state at this time whether residual disability will be or whether future surgery will be recommended. Today we have advised that she use her hand splint for performing activities which cause extension of the wrist."

The patient was examined by the authors on October 28, 1977; she complained of pain in the right wrist during activities such as using a screw driver, a broom, a vacuum cleaner, lifting heavy plants, and writing a letter. She had no complaints referable to the left wrist. The past medical history was irrelevant.

On physical examination the circumference of both wrists and forearm was equal. The patient alleged tenderness on pressure over the anatomic snuff box, the ulnar aspect of the wrist, and the distal region of the forearm. The ranges of motion of both wrists were identical. Examination of the left wrist was negative.

\* Presented at the Annual Meeting of the Mid-Central States Orthopaedic Society, Colorado Springs, Colorado, April 26-29, 1979.



Roentgenographic examination of both wrists was made on October 28, 1977. The films of the left wrist were negative. The various projections of the right wrist showed the navicular to consist of two components; a large and small segment of which the apposing margins were smooth and clearly defined with a definite cortical structure giving the appearance of a joint. There was no evidence of osteoporosis, increased density or cystic formation of either segment (Fig. 1). Subsequently, all previous films beginning with the original study taken on November 4, 1976 were obtained and reviewed. There were no differences in the radiologic findings compared with the films taken on October 28, 1977. These comparative studies verified the diagnosis of bipartite navicular.

## Discussion

Pfizzner<sup>16</sup>, an anatomist, is credited with the accepted description of the morphologic development and comparative anatomy of the carpal bones in 1900. It serves no purpose in this discussion to relate the details of this study. In brief, the carpal navicular is usually derived from one center of ossification; however, variations may occur. In those instances where two or more cartilaginous masses were formed, Pfizzner termed them *culare radiale* and *naviculare ulnare*, each of which developed a separate center of ossification. In those rare instances where the centers did not coalesce or fuse but continued to develop independently, a bipartite navicular resulted. In addition a third small segment, called the *os centrale*, may also have contained a separate center of ossification. Theoretically, if this center as well as the other two progressed independently, a tripartite navicular may result which is, indeed, a very rare anomaly if it exists at all.

Accurate knowledge of the normal anatomical development of the carpal navicular and the aberrant anomaly, the bipartite navicular, is essential in arriving at the correct diagnosis between non-union of a fracture and an anomaly. According to Rose<sup>19</sup>, a bipartite navicular is divided at the waist into more or less equal proportions; however, there are exceptions to this equality. The essential differential anatomical points are the presence of a joint space between the two pieces and the apposing surfaces are covered with cartilage. It has been suggested that the correct diagnosis can only be verified when such an anatomical joint is found by surgical exploration.<sup>2</sup> This procedure is unnecessary and impractical since there are several factors which, if carefully and thoughtfully weighed, can result in the correct diagnosis.



Fig. 1. Right wrist. See text.

Some authors consider bilaterality to be proof positive for acceptance of bipartite navicular as a clinical entity.<sup>12,25</sup> When present, this condition does not *sui generis* give rise to any disability.

The vast majority of authors consider bipartite navicular to be a congenital anomaly which may either be unilateral<sup>2,6,13,24</sup> or bilateral<sup>3,4,7,9,13,19,20,21</sup>. It may occur as an isolated instance or in conjunction with other congenital anomalies of the hand or forearm.<sup>17</sup> Golasch<sup>8,9</sup> added hereditary and familial factors in reporting this abnormality in ten members of a family. Another presumptive etiologic consideration, which is mentioned only in the German literature, is decreased function of the thyroid gland resulting in a disturbance of the normal course of ossification of the carpal navicular.<sup>1,11,17</sup>

The criteria of the clinical and roentgenographic characteristics in the differential diagnosis between non-union of a carpal navicular fracture and a bipartite navicular must be clearly understood and rigidly adhered to in order not to fall into error. The type of trauma

involved in the latter, when present, is either slight or is usually not sufficiently severe to produce a fracture.<sup>25</sup> Moreover, the physical findings are minimal or absent. Comparative films of the opposite side may reveal the same condition in which there is no history of trauma.<sup>24</sup> Childress<sup>5</sup> reported a unique case of fracture of a bipartite carpal navicular.

Because roentgenographic findings are one essential key to the accurate diagnosis, the films must be carefully analysed. In bipartite navicular the texture and density of both pieces of bone are identical. Osteoporosis and cyst formation, which are chief characteristics of non-union, are absent. Moreover, avascular necrosis which is manifested by increased density of one or both fragments, does not occur in bipartite navicular. In an acute fracture there is some irregularity of the contiguous edges of the fragments as contrasted with the smooth edges of bipartite navicular. The fracture line becomes more evident within a period of a week to

ten days whereas there is no change in the amount of separation of the joint surfaces of the congenital anomaly. With the passage of time, regardless of the interval, the findings in a case of bipartite navicular show no changes whatsoever in contrast to the progressive characteristics seen in developing non-union.

## Conclusion

Although we respect those opinions to the contrary<sup>14,23</sup>, the authors believe that there is sufficient documentation in the literature which has withstood the test of critical analysis to warrant the acceptance of the diagnosis of bipartite navicular as a distinct entity. One must be thoroughly familiar with its characteristics in order to distinguish this condition from non-union of the carpal navicular. The case reported stresses the importance of making the correct diagnosis especially in compensation cases. ●

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# Sleep hypoxemia

## *Growing Clinical Awareness*

David W. Hudgel, MD, and David W. Shucard, PhD, Denver, Colorado

*"O Sleep Why Dost Thou Leave me?" William Congreve verse for song by Handel*

*This article reviews the physiology, clinical presentation, evaluation, and therapy of breathing disorders resulting in sleep hypoxemia. These disorders can result in daytime somnolence, intellectual deterioration, impotence, depression, and essential hypertension. Sleep hypoxemia may precipitate life-threatening cardiac arrhythmias. Now that sleep hypoxemia can be easily diagnosed, it is being found regularly in obese individuals, in patients with respiratory diseases, and in otherwise normal individuals.*

### *Introduction*

Largely due to technicological advances which allow the clinician to measure arterial oxygen saturation noninvasively, an increasing number of individuals with previously unsuspected sleep hypoxemia are now being identified. Not only has sleep hypoxemia been found in those with symptoms of a sleep disturbance, it has also been identified in patients with respiratory diseases, abnormalities of respiratory control, obesity, and also in asymptomatic otherwise healthy individuals. It is the purpose of this communication to review the various physiological factors that contribute to sleep hypoxemia, to consider its varied clinical presentations, and to discuss currently recommended therapies.

### *Causes and Consequences of Sleep Hypoxemia*

Sleep hypoxemia can be attributed to seven essential causes: 1) alveolar hypoventilation, 2) ventilation-perfusion mismatch, 3) central apnea, 4) upper airways obstructive apnea, 5) bronchoconstriction, 6) mucus accumulation, and 7) altered controls of ventilation.

**Alveolar hypoventilation** occurs whenever the minute ventilation decreases or the dead space (wasted) ventilation increases. Alveolar hypoventilation results in a decrease in the arterial oxygen tension ( $PO_2$ ) and an increase in the arterial carbon dioxide tension ( $pCO_2$ .) This process occurs normally during sleep, but is considered abnormal if it becomes too extensive. Alveolar hypoventilation may be idiopathic or caused by other factors.

**Ventilation-perfusion mismatch** occurs when the alveolar air and capillary blood in the lung do not come into close contact for a long enough period of time. This abnormality can occur 1) when the air does not reach enough of the alveoli around which blood is being perfused such as occurs in chronic airways disease, 2) when the blood does not reach alveolar capillaries that are being supplied with air such as occurs in pulmonary vascular occlusive disease, 3) if the alveolar capillary barrier thickens, such as in congestive heart failure or pulmonary fibrosis, or 4) when pulmonary perfusion is poor, as in myocardial insufficiency.

**Central apnea** is characterized by cessation of all respiratory activity for a short period of time. It normally occurs during transition from drowsiness to light sleep or during rapid eye

Dr. Hudgel is Director of Ambulatory Services at National Jewish Hospital and Associate Professor of Medicine at the University of Colorado Health Sciences Center. Dr. Shucard is Director of the Brain Sciences Laboratory at the National Jewish Hospital, and Associate Professor of Psychiatry at the University of Colorado Health Sciences Center.

movement (REM) sleep. Central apneas that last longer than ten seconds or occur during deep sleep are considered abnormal. The longer these episodes last the greater the hypoxemia that develops.

**Upper airways obstructive apnea** is often found in adults who are heavy snorers. Most individuals with this problem are obese. It can also occur in children with severe tonsil and adenoid hypertrophy. In some of these individuals pharyngeal muscles become atonic for unknown reasons. Upon inspiration the atonic lateral and posterior pharyngeal walls collapse into the airway causing obstruction.<sup>1</sup> Increasingly vigorous thoracic and abdominal inspiratory muscular activity develops until the obstruction is finally broken. As the obstruction is broken there is a loud snore which usually arouses the patient and his bed partner. This cycle often recurs repeatedly during light sleep; the patient never achieves a normal sleep pattern, in that he cycles between wakefulness and light sleep, and never attains deep sleep. This lack of normal sleep leads to daytime somnolence. The thoracic movements that are made in an attempt to "break" the obstruction are so vigorous that they cause extremely negative intrathoracic pressure, resulting in pooling of blood in large thoracic veins and thereby decreased cardiac output.<sup>2</sup> Both the airways obstruction and decreased cardiac output contribute to the hypoxemia of upper airways obstructive apnea. Both central and obstructive apnea can occur in the same individual; this is termed mixed or complex apnea.

Patients with asthma and chronic obstructive airways disease (COPD) can develop **bronchoconstriction** during sleep. Airways disease itself is partially contributory. In addition, airway tone can change considerably during REM sleep. Since the arousal response to hypoxia, hypercapnia and mechanical loading is decreased during REM sleep, many of these patients do not awaken until severe bronchoconstriction and hypoxemia have occurred.

**Mucus accumulation** takes place in the airways, since during sleep bronchial ciliary activity is decreased. These mechanisms can contribute to severe sleep hypoxemia in asthmatics and COPD patients.

Central nervous system mechanisms producing **altered controls of ventilation** may also be a causative factor in sleep hypoxemia. For example, as mentioned above, changes in the respiratory center activity occur during sleep. As a result, arousal responses to chemical stimuli (e.g. hypoxia and hypercapnia) and mechanical stimuli are normally decreased during sleep, especially REM sleep. Severe sleep hypoxemia may occur when these normal mechanisms are present in individuals who have depressed respiratory center activity during wakefulness, as occurs in high altitude residents, in some patients with obstructive airways disease, in endurance athletes, and in those with primary alveolar hypoventilation (Ondine's Curse).

Sleep hypoxemia may lead to a number of complications. Both bradycardiac and tachycardiac arrhythmias have been reported during sleep hypoxemia.<sup>3 4</sup> These arrhythmias coupled with hypoxemia may be life-threatening. In addition, recurrent episodes of hypoxemia lead to pulmonary arterial constriction. If these episodes occur frequently, sustained pulmonary hypertension may result. In some individuals pulmonary hypertension leads to secondary systemic hypertension.<sup>3 5</sup>

### *Prevalence of Sleep Hypoxemia*

Although the prevalence of sleep hypoxemia in the general population or even in specific patient categories is unknown, some information is available that illustrates that this problem is more common than we previously suspected, especially in overweight, older males.<sup>6</sup> Several studies have shown that healthy individuals hypoventilate a small amount during

TABLE 1

Symptoms That May Indicate Sleep Hypoxemia

- Snoring
- Restless sleep, or violent body movements
- Interrupted sleep, insomnia
- Somnambulism
- Enuresis
- Nightmares
- Morning headaches and/or nausea
- Daytime somnolence
- Depression
- Sexual dysfunction
- Intellectual Deterioration
- Behavioral changes



sleep.<sup>7,8</sup> If arterial oxygen status is normal during wakefulness, the normal amount of sleep desaturation may not be clinically important. However, as one would anticipate from the shape of the oxygen hemoglobin disassociation curve, a greater amount of sleep oxygen desaturation occurs for the same decrease in PO<sub>2</sub> the lower the original PO<sub>2</sub> (Figure 1).

### Obesity and Sleep Hypoxemia

As pointed out above, sleep hypoxemia may be more common in obese individuals. The following case reports of two patients studied in our laboratory illustrate a number of the pathophysiologic mechanisms of sleep hypoxemia that can occur in obese individuals.

The first was a 43 year old white male who complained of a moderate degree of snoring and restless sleep. He had no daytime symptoms. His body weight was 210 kg. (ideal body weight, 89 kg.), his hematocrit was 50 Vol%. Sleep analysis showed extreme hypoxemia with oxygen saturation frequently decreasing to below 70% (normal Denver arterial oxygen saturation 94% or greater). During light sleep, alveolar hypoventilation was present, characterized by hypoxemia and CO<sub>2</sub> retention; during deeper stages of sleep there was ventilation-perfusion mismatch. (Fig. 2) Subsequent use of nasal oxygen totally resolved his sleep hypoxemia.

A second obese male, whose body weight was 93 kg. (ideal weight 79 kg.), had a history of severe snoring, frequent arousals during sleep, and daytime somnolence. Nocturnal restless-

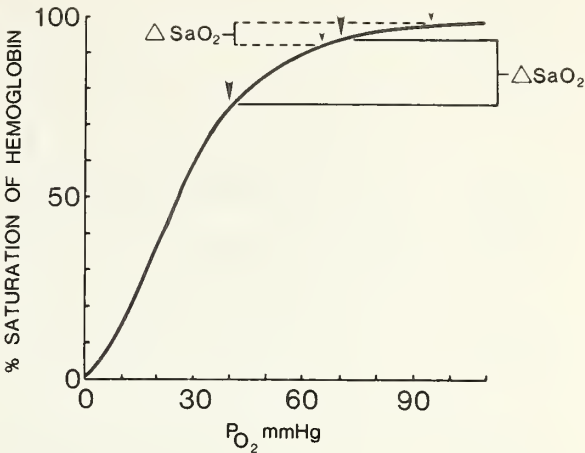


Fig. 1. The shape of the oxygen-hemoglobin dissociation curve dictates the amount of decrease in percent oxygen saturation of hemoglobin (SaO<sub>2</sub>) for a given decrease in arterial oxygen tension (PO<sub>2</sub>). For the same decrease in PO<sub>2</sub> if the initial level of PO<sub>2</sub> is low (large arrows), the decrease in SaO<sub>2</sub> is greater than if the initial PO<sub>2</sub> were higher (small arrows). A greater decrease in SaO<sub>2</sub> more adversely affects tissue oxygenation even though the PO<sub>2</sub> decrease is the same in both circumstances.

ness had driven his wife to sleep in another room. In addition, he was quite depressed, impotent, and displayed a lack of interest in his daily activities. His hematocrit was elevated. Sleep analysis showed repeated cycles of mixed apnea, central apneas followed by upper airways obstruction. (Fig. 3) As these cycles recurred throughout the night's sleep, arterial oxygen saturation occasionally fell below 50%. Oxygen and medroxyprogesterone did not help, and tracheostomy was required to bypass the obstruction. Following the tracheostomy, he had immediate relief of interrupted sleep, did not snore, and had total resolution of the daytime somnolence and behavioral changes.

These two patients illustrate four mechanisms of sleep hypoxemia: alveolar hypoventilation, ventilation-perfusion mismatch, central and obstructive apnea.

### Clinical Presentation

The symptoms of a sleep disturbance resulting in sleep hypoxemia are many and varied. It is important to remember that the history of sleep symptoms are best obtained from the spouse or from parents, if the patient is a child. Table 1 lists the most common symptoms of a sleep hypoxemia.

TABLE 2

Treatment for Causes of Sleep Hypoxemia

Diagnosis	Therapy
Alveolar hypoventilation	Weight loss if patient overweight 0 administration 2 Possibly, respiratory stimulants
Ventilation-perfusion mismatch	Weight loss if overweight 0 administration 2
Mucus accumulation	Bronchodilators at bedtime Postural drainage at bedtime Possibly, 0 administration 2
Upper airways obstructive apnea	Adenotonsillectomy Bypass: self-intubation, head brace, or tracheostomy
General apnea	Weight loss if overweight Respiratory stimulants Phrenic nerve pacing
Decreased ventilatory drive	Respiratory stimulants 0 administration 2

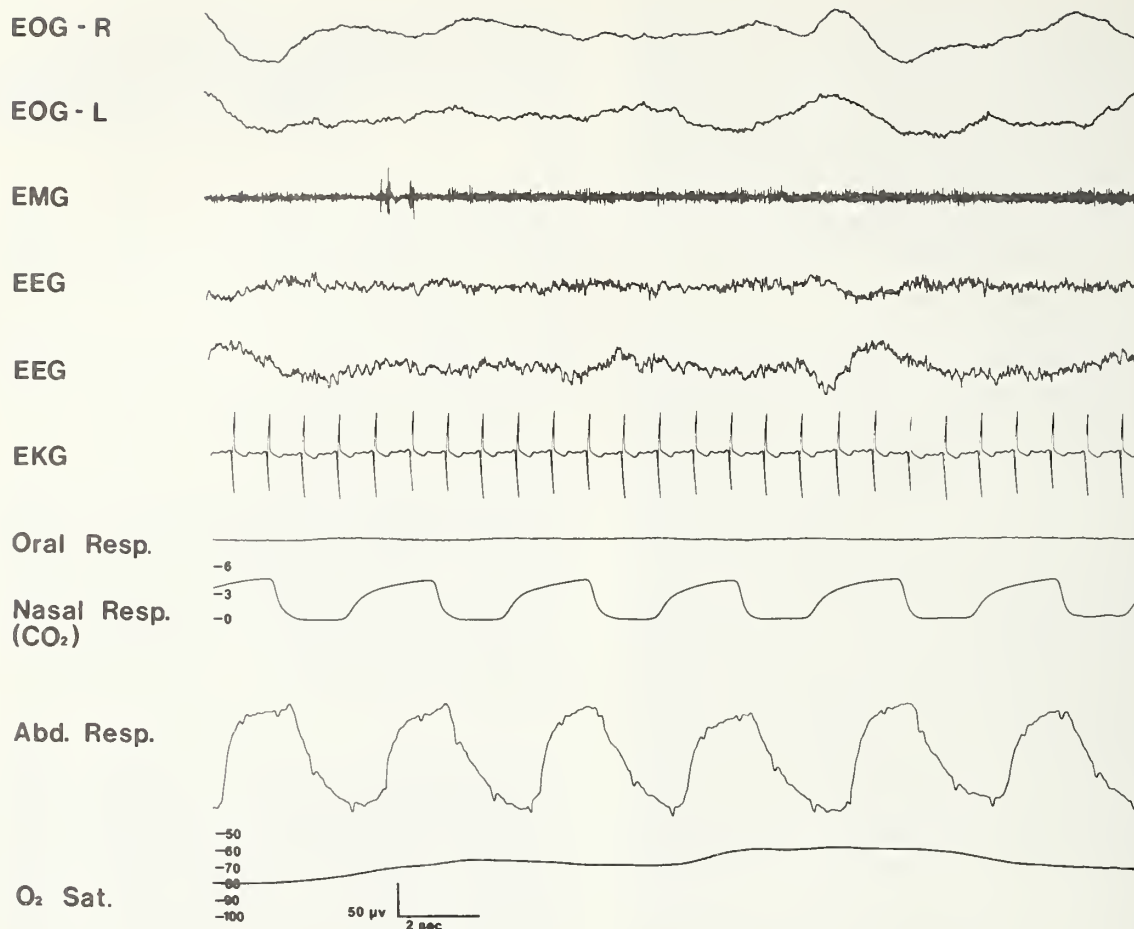


Fig. 2. Sleep analysis demonstrating hypoxemia related to ventilation-perfusion mismatch. In spite of normal ventilatory pattern seen in abdominal respiration (Abd. Resp.) and airflow (Nasal Resp.) recordings, there is severe arterial desaturation ( $O_2$  Sat.). EOG, electro-oculogram; EMG, mental electromyogram; and EEG, electroencephalogram are used for sleep staging, Stage I (light sleep) in this instance.

### Methods of Evaluation

A careful history obtained from both the patient and the spouse, or from the parents in the case of children, is of extreme importance in the evaluation of a sleep disturbance. When history of a possible sleep abnormality is obtained, the patient should first be observed by a trained person during normal sleeping hours. The observer should note sleeping positions, times and frequency of arousals, pattern of snoring, ventilation pattern and its relationship to snoring. In addition, cardiac monitoring should be performed. If sleep hypoxemia is suspected, monitoring of arterial oxygen saturation can be done noninvasively with an ear oximeter. If an oximeter is not available, an arterial cannula can be placed in the radial artery, and an exten-

sion added, so that blood samples can be withdrawn during sleep without awakening the patient.

If the initial observation indicates respiratory difficulties, sleep hypoxemia, or cardiac arrhythmias, a formal sleep study should be done. Sleep staging is done using electrophysiological techniques in which the electroencephalogram (EEG), electro-oculogram (EOG), and chin electromyogram (EMG) are simultaneously recorded. Ventilation patterns are recorded by a chest and/or abdominal strain-gauge. Nasal and oral airflow are monitored, one by a thermistor and the other by a capnograph. Arterial oxygen saturation is monitored by ear oximetry. Using these techniques, the relationship between sleep and ventilation abnormalities resulting in sleep hypoxemia can be clarified.



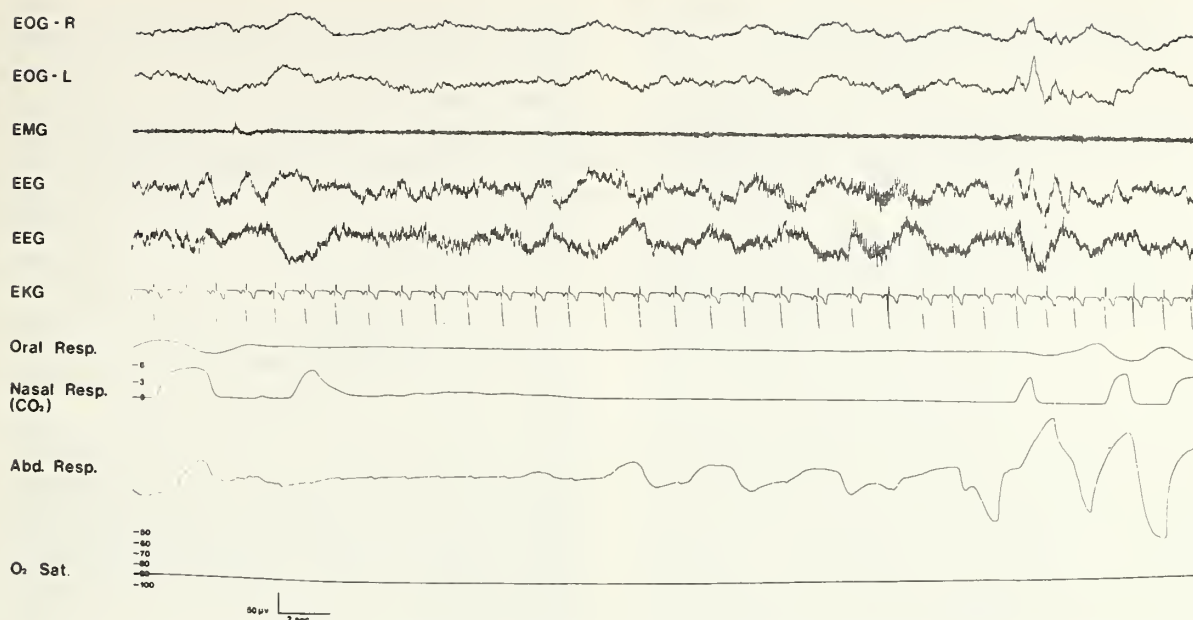


Fig. 3. Sleep analysis demonstrating mixed apnea during Stage II sleep. A period with no abdominal movement and no airflow (central apnea) is followed by a period of progressively increasing abdominal respiratory activity without airflow at the nose or mouth (obstructive apnea). This apneic spell is accompanied by gradually decreasing oxygen desaturation.

## Therapy

Table 2 summarizes the major diagnoses and recommended therapies for sleep disorders related to respiratory disturbances. Indications for therapy are 1) a sleep disorder resulting in daytime symptoms such as somnolence, intellectual deterioration, depression, etc., 2) severe sleep hypoxemia, and 3) cardiac arrhythmias or hypertension associated with sleep hypoxemia or a sleep disorder. If the daytime symptoms are related to a sleep disorder, they usually clear very promptly with resolution of the sleep disorder. The importance of the hypoxemia observed is weighed by factors such as the patient's age, the presence of coronary artery disease or cerebral vascular disease. Ventricular tachyarrhythmias and asystole should be considered potentially life-threatening, and should dictate immediate treatment of the sleep disorder with which the arrhythmia is associated.

As mentioned above, insomnia may be a symptom of a sleep disorder resulting in significant sleep hypoxemia. If hypnotic or sedative drugs are given to such patients, hypoxemia may worsen since these drugs pro-

duce alveolar hypoventilation. Therefore, sleep should be analyzed in the insomniac before prescribing sedative agents.

If alveolar hypoventilation or ventilation-perfusion mismatch is shown to be the mechanism of sleep hypoxemia, oxygen therapy will be helpful. However, the causes of hypoventilation or ventilation-perfusion mismatch should be determined so that therapy for the underlying condition might be initiated. If obesity is also present, a weight loss program should be vigorously pursued. In cases where sleep hypoxemia is due to bronchoconstriction, intensified bronchodilator therapy prior to bedtime and/or at intervals during sleep is recommended. In patients with mucus accumulation during sleep, postural drainage at bedtime may be helpful in addition to bronchodilators. Supplemental nighttime oxygen may also be needed in these patients.

The treatment of obstructive and central apnea has received much attention lately. No medications have been found to be effective in reversing obstructive apnea.<sup>9</sup> If obstructive apnea is responsible for severe hypoxemia, cardiac arrhythmias, pulmonary hypertension,

systemic hypertension, or significant daytime somnolence, a procedure to bypass the pharyngeal muscles is indicated. Children with obstructive apnea who have hypertrophied adenoids or tonsils should have an adenotonsillectomy. Some adults can learn self intubation; intubation to a level just above the larynx is usually satisfactory. Others have been treated successfully by using braces to position the head to eliminate the obstruction. The most reliable form of therapy for obstructive apnea has been a small tracheostomy which can be closed during the daytime for normal voice functioning.<sup>10</sup> For central apnea, respiratory stimulants such as aminophylline, naloxine, medroxyprogesterone, and clomipramine have been used with minimal success.<sup>11</sup> If no respiratory stimulants resolve severe hypoxemia due to central apnea, phrenic nerve pacing may have to be considered.<sup>12</sup> Medroxyprogesterone is a respiratory

center stimulant. It has been useful in obese hypoventilators<sup>13</sup> and in hypoxemic individuals with chronic high altitude sickness<sup>2</sup>, but its use in central apnea has not been fully clarified.

The severity of hypoxemia observed in some patients, and its potentially life-threatening complications, indicates the importance for clinicians to ask susceptible patients, such as children with nasal voices or recurrent tonsillitis, obese individuals, respiratory disease patients, and those with changes in intellectual or behavioral functioning, about symptoms of a sleep disorder. If a suggestive history is obtained, a sleep analysis should be done to confirm the history and to identify the presence of hypoxemia and the mechanisms of the sleep disorder. Only after such an evaluation can therapeutic measures be initiated that may resolve, or at least compensate for sleep hypoxemia.●

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# Lidocaine and the hyper-acute back

Charles D. Magill, MD, Englewood, Colorado

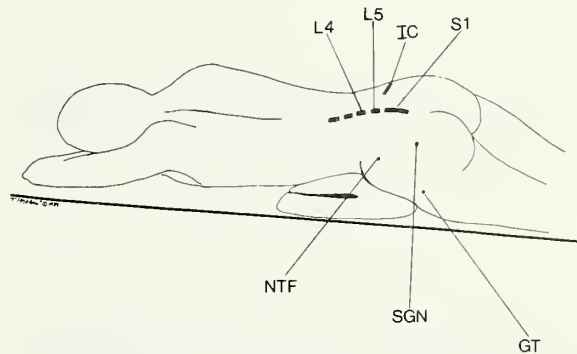
**The Problem:** Jim Jones is unloading the trunk of his car. As he is setting a bag of cement on the ground to his right, his back "goes out," and he slides to the ground in pain. With much effort and commotion, he arrives in the waiting room. He is forty-nine years old, in obvious distress, listing to the right, supported as he walks by a coworker, holding his right low back.

**The Procedures:** Place the patient on an examination table, face down, with a doubled-up pillow placed under his abdomen (figure 1). Expose the low back. Stand at his left side. With a pen or marker, draw a short transverse line at the right posterior iliac crest (IC), a vertical line at the posterior spinous process of the sacrum (S1), and short vertical lines over each posterior spinous process up to D12 ("L5", "L4", etc.).

Palpate the processes and nearby paraspinal muscles vigorously up to D11. The maximum tenderness is usually from L4 to S1 and usually on one side only. However, it may seem to involve the nerve to tensor fascia (NTF), superior gluteal nerve (SGN), sacroiliac joint, or greater trochanter (GT).

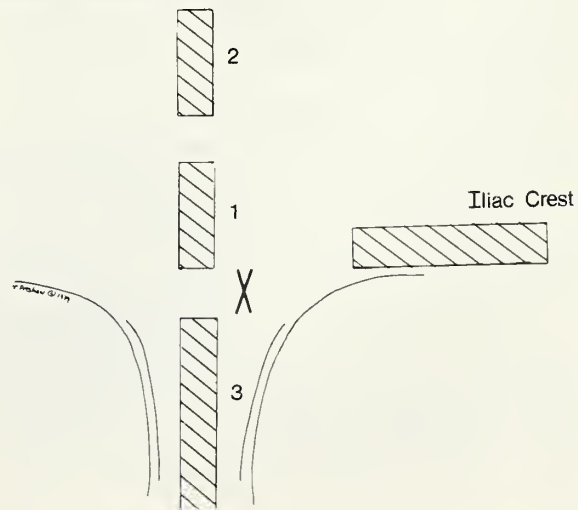
Prepare a 10 cc. solution of lidocaine 1% on a number 21 or number 22 one and one-half inch needle. Do not use 2% lidocaine as this would have too much chance of adverse reaction. Select a site one inch lateral to the midline of the L5 posterior spinous process ("X" in figure 2). Cleanse the area with two or three alcohol sponges. Propel the needle and attached syringe straight, not medial, not lateral, until bone stops its progress. Medially, the needle would contact neural elements, laterally, it will miss the main target. Inject 4 cc. of 1% lidocaine ("1" in figure 2). Redirect the needle superiorly about one and one-half inches ("2") and inject 3 cc.; then, distally, one and one-half inches ("3") and inject the remaining 3 cc.

**The Precaution:** To avoid neural injection, the patient must be coaxed into the prone position with the elements marked off. The physician must not direct the needle medially. Follow the usual manufacturer's lidocaine precaution. In the event of spinal anesthesia, tilt the head upwards slightly, maintain usual supportive measures, and await recovery. This has not occurred in the author's experience.



**The Result:** The patient will usually feel much better and be able to walk and go home where he can pursue usual measures for the sub-acute or chronic back. These might include medications, corset, and outpatient physical therapy. If the procedure is not successful, transfer the patient to the hospital. Herniated disc, compression fracture, kidney stone, pelvic fracture, pathologic fracture can usually be detected with usual evaluation. The lidocaine would not adversely affect these conditions.

**The Advantage:** Hospitalization is avoided.



## AAMA STRENGTHENS PHYSICIANS' LIAISONS

The physicians' office personnel are the initial contact with patients. The impressions they give play a significant role in how your patient perceives quality professional care. Medical assistants, persons employed by or working under the supervision of physicians, are in a very important position of trust and responsibility, one in which they constantly deal with public relations, thereby affecting the medical professions' image. A competent staff provides the physician with many benefits. The medical assistant is one of the physician's most important allies in the successful practice of medicine. The medical assistant is next to the physician in patient care and satisfaction, and is the physicians' liaison in providing professional services.

### **THERE IS A WAY TO ENCOURAGE YOUR OFFICE STAFF TO DO A BETTER JOB OF HELPING YOU:**

The American Association of Medical Assistants was organized in 1955 to inspire medical assistants, secretaries, nurses, technicians, bookkeepers and receptionists to give honest, loyal and efficient service to their physician-employers as well as to the public. This is a non-profit professional organization that is dedicated to providing educational services to increase the knowledge and professionalism of its members, and to strive at all times to cooperate with the medical profession in improving public relations.

AAMA is recognized and sanctioned by the AMA and CMS. Physician advisors serve at all national, state and local levels of AAMA, giving advice and counsel. The AAMA, Colorado Society, prohibits its members from ever becoming a trade union or collective bargaining agency.

American Association of Medical Assistants meetings offer continuing education to its members through organized educational activities. Seminars, workshops and study groups provide programs covering a wide variety of subjects, on the latest developments in the

health care field relating both to administrative and clinical medical assistants. The Colorado Society of AAMA is currently sponsoring a CPR session in conjunction with the Colorado Medical Society Interim Session, to be held Saturday, March 1, 1980, at Writers Manor, Denver.

This tri-level organization also grants national certification to the medical assistant on the successful completion of a national examination. The National Board of Medical Examiners is the consultant for this AAMA/AMA sponsored program. A Certified Medical Assistant in the physicians' office is an assurance of a knowledgeable and competent, well-trained and motivated employee. AAMA's educational programs that meet specific guidelines also provide the opportunity to obtain continuing education unit credit. Additional benefits of membership include professional journals, optional group insurance, loan and scholarship programs, state and national conventions, and personal growth for the physicians' staff.

National membership encompasses 19,000 medical assistants in 47 states. Colorado Society has 260 members in 7 areas: Chapters are located in Denver (Capitol), Lakewood (Clear Creek), Colorado Springs (El Paso), Pueblo (Pueblo), Canon City (Fremont), Durango (La Plata), Evergreen (Mountain Area), plus members-at-large throughout the state.

The American Association of Medical Assistants believes that better trained assistants can assume more responsibility in maintaining smooth-running offices and save the physician valuable time. The AAMA member can keep informed and current with the advances and constant changes involved in today's complex practice of medicine. By encouraging membership in AAMA the physician-employer will receive more professional assistance and help to provide better patient care. If you or your staff members would like more information about membership in AAMA, you can contact: Doris Corey, CMS, Membership Chairman, 10175 Glennon Drive, Lakewood, Colorado 80226. Phone: 985-0936 or 394-8763, or visit with one of the AAMA members who will be present at the CPR session at the Colorado Medical Society Interim Session, on March 1, 1980, at Writers Manor, Denver.

by Mary Claire Attebery,  
Public Relations Chairman  
Colorado Medical Assistants



## CHINA GAINS PFIZER CT SCANNER

The People's Republic of China is preparing to further its medical capabilities by the addition of revolutionary CT scanners. Recently, at the Pfizer Medical Systems' CT manufacturing plant in Columbia, MD., Chinese journalists ended a tour of the plant observing the tunnel aperture of the Pfizer CT scanner.

The manufacturer will soon ship two of the CT scanners, purchased by the People's Republic of China, one to the People's Liberation Army Hospital, Peking, and the other to Army Hospital, Xian.



The CT scanner, having reached a zenith in acceptance during the 1970s, is still considered to be the most important advance in medical diagnosis since the turn of the century.

## Republic of China Medical Tour Set To Go

The Medical Tour to the People's Republic of China is now a reality. The group of 34 will include physicians, nurses, a ward clerk, social and psychiatric workers, members of auxiliaries and a dialysis nurse.

We will leave Denver on August 8, 1980, spend a night in Tokyo, arriving in Peking on August 10. The group will then be in mainland China until August 25, 1980, visiting hospitals (the group will go on rounds with doctors in clinics, visit a tuberculosis clinic, witness surgery under acupuncture, visit barefoot doctors at rural health clinics) and we have been promised that this will be a "topnotch" medical tour. Also included will be visits to other points of interest in the country and the cities. The entire tour is under the auspices of the hosting Chinese.

The tour leaves Canton on August 25, staying three nights in Hong Kong to rest up before winging back to the U.S. on August 28. The

price is \$2,995.00, which includes everything but airport taxes, which cannot be prepaid.

I have openings for five persons, and would like to have the tour filled. Please contact me immediately if you are interested because shortly after January 1 we must apply for visas. Please have an up-to-date passport, since the passport will be needed for visa applications. If you are interested, please call or write me immediately. I can be reached by telephone, after 6 pm, in Denver at (303) 935-5307. Or, you can write to: Darlene A. Classen, R.N., 1936 South Quitman Street, Denver 80219. If you write to me, be sure to include your name, home address, and home phone (I will keep the number in confidence, in case it is unlisted, but I must have a home telephone number), and your specialty.

Our tour plans have been handled by Special Tours for Special People in New York. I have also been in direct contact with the Chinese International Travel Service.

Darlene A. Classen, R.N.



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# obituaries

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Major General **Carl Willard Tempel, MD**, died November 1, 1979 in Denver at the age of 76.

Doctor Tempel was born July 22, 1903, in Canton, Missouri. He received his BA at St. Louis University, St. Louis, Missouri and went on to take his MD there. On July 1, 1930 he was commissioned in the Army Medical Corps, and first assigned to William Beaumont General Hospital, at El Paso, Texas.

Later he served for the first of three times at Fitzsimons Army Medical Center and at Walter Reed Army Hospital, Washington, D.C. In October 1944 he was promoted to Colonel, and took command of the 309th General Hospital which he led in the Asiatic-Pacific Theatre in June 1945.

Before returning for the second time to Fitzsimons, Dr. Tempel served in the Far East in a variety of capacities. At Fitzsimons in 1947 Dr. Tempel was an assistant chief and later chief of medical service, during which time he concentrated on treatment and rehabilitation of tuberculosis patients.

In July 1955 Dr. Tempel became medical consultant to the Army's chief surgeon, Far East Division. His work in tuberculosis surveys was distinguished by the personal commitment of his attention. In May 1957 he returned to the United States to take command of Valley Forge General Hospital at Phoenixville, Pennsylvania, at which time he became Brigadier General.

In September 1958 Dr. Tempel became chief of the Professional Division in the Office of the Surgeon General, and in September 1960 with the rank of major general he became commandant of Fitzsimons, and in 1962 he retired from the service and held positions in Denver at National Jewish Hospital at the Webb-Waring Lung Institute, and later as a tuberculosis consultant for the Colorado Department of Health on a volunteer basis.

He received a Distinguished Service Medal from the U.S. Army, its highest peacetime award, in August, 1962, and in May of 1969 received the Faculty Service Award of the University of Colorado.

He was a member of the Adams-Aurora Medical Society, the Colorado Medical Society, and the American Medical Society. He belonged to the American Thoracic Society, the American College of Physicians, and the American College of Chest Physicians.

He is survived by his widow, Ruth, and two daughters, Doris M. Markham, Longmont, Colorado, and Mary R. Miller, Pebble Beach, California, and a son, Col. Thomas R. Tempel, Washington, D.C.

Doctor **Kenneth E. Gloss** died in Colorado Springs December 1, 1979 at the age of 67.

Doctor Gloss was born January 12, 1912 in Oberlin, Kansas, and in 1922 moved with his family to Colorado Springs where he attended public schools. He

was graduated from Colorado College in 1934, and in 1938 was graduated from the University of Colorado Medical School. He took his internship and residency in obstetrics and gynecology at Colorado General Hospital.

He practiced briefly in Crystal Falls, Michigan and then entered the Army Air Corps as flight surgeon, serving at San Angelo, Texas; Lincoln, Nebraska; Kearns, Utah, and Okinawa. He left the service as lieutenant colonel.

In 1948 he returned to assume a private practice in Colorado Springs. He served on the medical staffs at St. Francis and Memorial hospitals, and was president of the medical staff at St. Francis Hospital. He also served at Penrose Hospital. He was president of the El Paso Medical Society and was a member of the Colorado Medical Society.

Doctor Gloss is survived by his widow, Clara, four sons, Kenneth E. Gloss II, Littleton, Colorado; Peter J. Gloss, Ogden, Utah; Frederick C. Gloss, McLean, Virginia; Lawrence R. Gloss, Denver; and a daughter Kathryn U. Anderson, Denver, and four grandchildren.

Doctor **George Glen Balderston** died August 20, 1979 in Montrose at the age of 60.

He was born in Clifton, Kansas on January 27, 1919. When he was very young his family moved to Paonia, Colorado where he attended public schools. He attended the University of Colorado, and received his MD in 1947. He interned at Colorado General Hospital during 1947-48. He had served in the U.S. Navy Reserve from 1942 to 1945.

His first practice was in Telluride, and in 1950 he served in the U.S. Navy Medical Corps in Korea. He moved to Montrose in 1952 upon his return to the United States, where he practiced until illness forced his retirement July 1, 1978.

Dr. Balderston received the Robins Award in 1977 for his remarkable sense of community regard and involvement. He was active in the Montrose County Medical Society, and served as president from 1964 to 1966. He was a member of the Colorado Medical Society and the American Medical Society. He was a Fellow of the Academy of Family Practice.

Dr. Balderston had been a member of the Civil Air Patrol, the American Association of Flying Physicians, and had been for twenty years a Federal Aviation Medical Examiner.

He is survived by his widow, Jean, and six children. A son Douglas, Pleasant Hill, California, and five daughters survive. They are Cynthia Risch, Montclair, California; Pamela Parker, Denver; Sheila Sorrells, Grand Junction; Tina Wilson, Ridgeway, and Michelle Phillips, Buena Vista.

Doctor **Harry Carpenter Hughes** of Denver died September 22 at the age of 73.

Doctor Hughes was born in Chillicothe, Missouri August 24, 1906. His family moved in 1912 to Council Grove, Kansas, and in 1914 moved east of Colorado Springs. His father was a well known constructor of golf courses, among which he built Wellshire and Cherry Hills.



Doctor Hughes attended the Cheyenne Mountain School in Colorado Springs and then took pre-med courses at the University of Denver. He was graduated with his MD in 1933 from the University of Colorado School of Medicine.

He interned at Youngstown Hospital in Ohio from 1933 to 1934, following which he returned to Colorado where he established a general practice in Englewood. From 1935-36 he was resident physician at The Children's Hospital, Denver.

In 1937 Doctor Hughes took work in orthopaedics at Boston City Hospital, Massachusetts General Hospital, and at Boston Children's Hospital, returning in 1938 to Colorado where he established a practice in orthopaedics in Denver.

He joined the Army Medical Corps as a Captain in 1942, and became associated with the 31st General Hospital and spent 24 months in the Pacific theatre of Operations, leaving the service in March 1945 as a lieutenant colonel to return to practice in Denver.

He became an associate clinical professor of orthopaedic surgery at the University of Colorado School of Medicine, a staff resident at Presbyterian Medical Center, Children's Hospital, and Denver General Hospital, and an associate staff member at St. Joseph, St. Luke's, and Mercy hospitals, and a consultant at Fitzsimons Medical Center.

Doctor Hughes was a member of the Denver and Colorado medical societies and the AMA. He was president of the Western Orthopaedic Association in 1969, a certified member of the American Board of Orthopaedic Physicians, and a fellow of the American Academy of Orthopaedic Surgeons.

Doctor Hughes was married in 1936 to Jean Clawson, who survives, as do a daughter, Mrs. Cynthia Wilson, Fort Worth, Texas, and a son, John M. Hughes, Soldotna, Alaska, two brothers, Frank, Rancho Mirage, California; and Harry, Denver.

Doctor **James D. Ripepi** of Lakewood, Colorado died October 13, 1979 at the age of 54.

Doctor Ripepi was born March 20, 1925 in Philadelphia. He attended Jefferson Medical College and received his MD there in 1950, following which he served a rotating internship at Delaware Hospital, Wilmington, Delaware. He studied under a fellowship in psychiatry at the Mayo Foundation and Clinic at Rochester, Minnesota for 3-¼ years, and a residency in neurology at Jefferson Medical College, Philadelphia for two years.

Doctor Ripepi was an instructor in neurology at Jefferson Medical College, and directed adolescent services at Miseracordia Hospital in Philadelphia prior to being appointed associate chief of the children's division at Fort Logan Mental Health Center, Colorado in November 1968. He left Fort Logan in 1971 when he had become director of the Geriatrics Division, and entered private practice.

He is survived by his widow, Ann, and four children, a son, Jonathan David, and three daughters, Amy, Joan, and Anita.

Doctor **Walter Joseph Longeway** of Denver died in Chicago September 22 at the age of 70.

Doctor Longeway was born in Council Bluffs, Iowa on September 8, 1909, and received his BA and MD from Creighton University, Omaha. He interned at St. Joseph Hospital, Denver in 1935-36, following which he practiced general surgery in Denver.

During World War II he served in the U.S. Navy medical department from 1942 to 1945, following which he became chief surgeon of the Colorado and Southern Railway. He was deeply involved in various railroad and civil service activities. He became President of the medical section of the Association of American Railroads. Later he was chairman of the executive board of the Association of Railroad Surgeons.

He was a fellow of the International College of Surgeons and the Southwest Surgical Congress, a charter member of the Academy of Family Physicians, and a member of the Denver and Colorado Medical societies and the American Medical Association.

He is survived by his widow, Mrs. Winifred Longeway, two daughters, Mrs. Kathryn Ann Page and Mrs. Janet Claire Weekly, both of Denver, a son, Walter J. Longeway, Jr., Denver, and a sister, Gertrude Leick, Council Bluffs, Iowa.

## Wyoming

Doctor **W. Andrew Bunten** of Cheyenne, Wyoming, a former vice president of the American Medical Association, died July 30, 1979 at the age of 82.

Doctor Bunten was born August 22, 1896 in Pawnee City, Nebraska, and attended Grinnell College where he received a BA, then attended the University of Nebraska from which he received a BS, and in 1922 received an MD from that University's medical school.

He took his internship at University Hospital, Omaha, and practiced in Worland and Basin, Wyoming from 1923 to 1927. From 1927 to 1929 he was a Fellow at Mayo Clinic. In 1929 he became chief of the neurosurgery subdivision at Grace Hospital, Detroit. In 1931 he commenced medical practice in Cheyenne.

He served as president of the staff of Memorial Hospital in 1943. From 1938 to 1948 he served as Union Pacific Railroad surgeon, and from 1948 until 1943 when he retired he was district surgeon of the Union Pacific Railroad Employees Hospital Association.

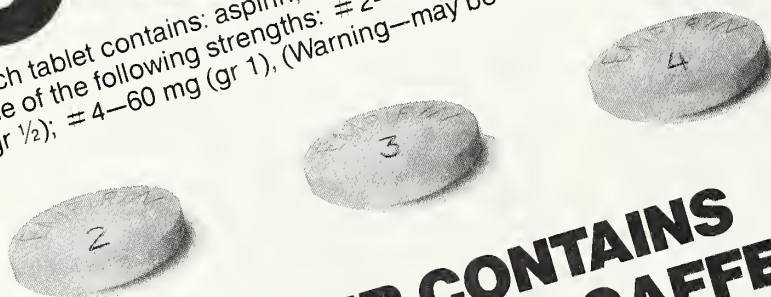
He was a member of the Wyoming State Medical Society, and from 1952 to 1956 was a delegate to the AMA. In 1952 he served as president of the Conference of Presidents of the AMA. During 1965-66 he served as vice president of the AMA. In many ways he was active both on AMA and State society activities.

Doctor Bunten was a member of the Cheyenne Frontier Days Committee, and from 1958 to 1960 was parade chairman for this event.

He is survived by his widow, Elsa.

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## CME Programs Set

February will see two outstanding CME programs presented in western slope communities of Colorado.

On February 8 and 9 a program entitled "Wellness - Toward a Goal of Optimum Health" will be presented at the Ramada Inn Convention Center in Grand Junction, Colorado.

Subtitled "A Conference in Holistic Medicine," the program will provide 13 hours of Category 1 AMA credit for the physicians. Nurses and other allied health professionals are invited for a similar amount of credit, which has been applied for. The AMA credit is in addition to AAFP credit, also applied for.

Participating in this program will be a number of featured guest lecturers, among them: Kenneth R. Pelletier, PhD, of Berkeley, California, author of the book, "Mind as Healer, Mind as Slayer," dealing with stress disorders. The subject of Mr. Pelletier's presentation is "From Stress to Optimum Health."

A second outstanding lecturer will be Andrew T. Weil, MD, speaking on "Altered States of Consciousness." Doctor Weil is a graduate of the Harvard Medical School and is soon to publish a book entitled "The Marriage of the Moon and the Sun." He is well known for his study and work in drug addiction.

Third is Rudolph Ballentine, MD, speaking on "Holistic Therapy." Doctor Ballentine comes to the lecture series from his work with the Himalayan International Institute in Honesdale, Pennsylvania.

This two-day program will cover the main topics of the importance of self-responsibility for one's health, the interrelationship between stress and disease, stress management and, finally, the importance of fitness to exercise.

The "Wellness" conference will include small group workshops at the conclusion of the formal presentations. Registration for this program is requested by February 1, 1980.

The second program, "Mountain Medicine," will be presented on February 22nd through the 24th at Ouray, Colorado. This program is being co-sponsored by the Western Colorado Area Health Education Center (AHEC, a division of the University of Colorado SEARCH program).

This program begins on Friday at the Elk's Lodge in Ouray, and continues through Sunday, February 24. Speakers include William J. Mills, Jr., MD, from Anchorage, Alaska, and Herbert Hultgren, MD, from Palo Alto, California. Their main topics will be the general medical problems of high altitude, hypothermia and frostbite. This program will provide 11 hours AMA Category 1 credit. AAFP Credit has been applied for. Registration for this program is requested by February 15, 1980.

For further information on either of these conferences contact Patrick G. Moran, MD, St. Mary's Hospital and Medical Center, Grand Junction, Colorado, telephone (303) 242-1550, ext. 500.

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## new officers

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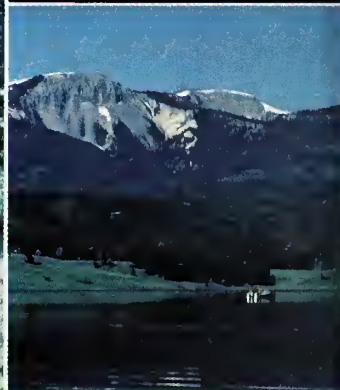
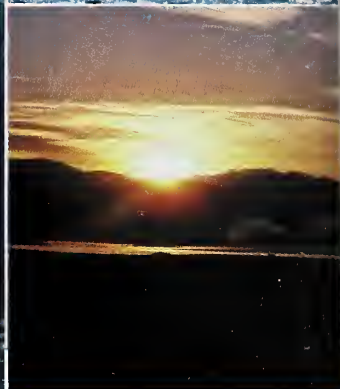
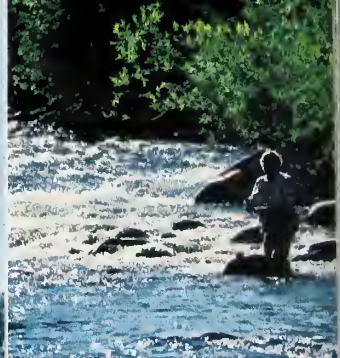
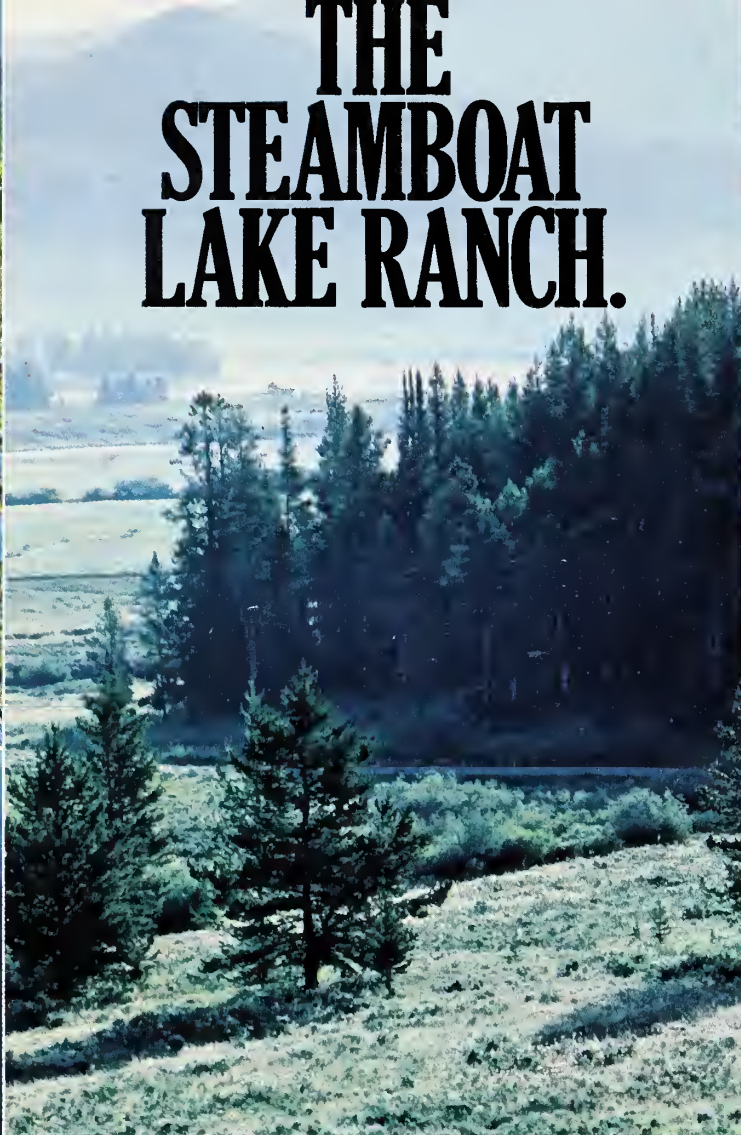
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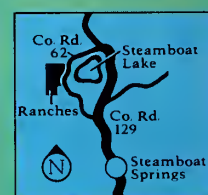
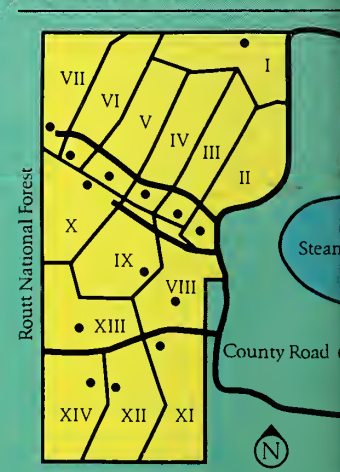
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*Colorado Medicine* (ISSN-0035-760X) is published monthly for \$12 per year by the Colorado Medical Society, 1601 East 19th Avenue, Denver, Colorado, 80218. Second-class postage paid at Denver, Colorado. POSTMASTER: Send address changes to *Colorado Medicine*, 1601 East 19th Avenue, Denver, Colorado 80218.

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# book corner

## PHYSIOLOGY

**Best & Taylor's Physiological Basis of Medical Practice:** John R. Brobeck. 10th ed. Baltimore, Williams & Wilkins, 1979. 1 v. Various pagings. \$28.00

**Treatment of Injuries to Athletes:** Don H. O'Donoghue. 3rd ed. Philadelphia, Saunders, 1979. 834 p. \$31.50.

## PATHOLOGY

**Adjuvant Therapy of Cancer:** International Conference on the Adjuvant Therapy of Cancer, Tucson, Ariz., 1977. Sydney E. Salmon and Stephen E. Jones. New York, North-Holland Publ. Co., 1977. \$57.50.

**Cancer Chemotherapy III:** Isadore Brodsky, ed. New York, Grune & Stratton, 1978. 493 p. \$39.50.

**Nutritional Management of the Cancer Patient:** Joy J. Wallard, ed. New York, Raven Press, 1979. 204 p.

## MEDICAL PROFESSION

**The Doctor's Law Guide; Essentials of Practice Management.** Philadelphia, Saunders, 1979. 100 p. \$15.00

**The Management of Medical Practice:** John McCormick. Cambridge, Massachusetts, Ballinger, 1978. 392 p. \$20.00.

**Webster's Medical Office Handbook:** Anne H. Soulehanov and John R. Haverty. Springfield, Mass., Merriam, 1979. 596 p. Gift.

## PRACTICE OF MEDICINE

**Differential Diagnosis:** A. McGehee Harvey. 3rd ed. Philadelphia, Saunders, 1979. 738 p. \$35.00.

**Food, Nutrition and Diet Therapy:** Marie V. Krause and K.L. Mahan. 6th ed. Philadelphia, Saunders, 1979. 963 p. \$15.00.

**Quick Reference to Clinical Nutrition:** Seymour L. Halpern. Philadelphia, Lippincott, 1979. 414 p. \$16.95.

**Textbook of Medicine:** Paul B. Beeson, Walsh McDermott and James B. Wyngaarden, ed. 15th ed. Philadelphia, Saunders, 1979. 2 v. \$56.00.

## IMMUNOLOGIC DISEASES

**Asthma and the Other Allergic Diseases:** NIAID Task Force Report: U.S. Department of Health, Education and Welfare. Washington, D.C., G.P.O., May 1979. 676 p. Gift.

**Immunological Diseases:** Max Samter, ed. 3rd ed. Boston, Little, Brown and Co., 1978. 2 v. \$70.00.

## RESPIRATORY SYSTEM

**Complications of Intrathoracic Surgery:** A. Robert Cordell and Robert G. Ellison, ed. Boston, Little, Brown, 1979. 415 p.

**Blades' Surgical Diseases of the Chest:** Donald B. Effler, ed. 4th ed. St. Louis, Mosby, 1978. 839 p.

## UROGENITAL SYSTEM

**Nephrology:** Jean Hamburger and others, ed. New York, John Wiley & Sons, 1979. 1393 p. \$70.00.

**Principles and Management of Urologic Cancer:** Nasser Javadpour, ed. Baltimore, Williams & Wilkins, 1979. 533 p. \$49.95.

## PSYCHIATRY

**Antidepressant Treatment:** John H. Greist. Baltimore, Williams & Wilkins, 1979. 235 p. \$9.95.

**Homosexuality in Perspective:** William H. Masters and Virginia E. Johnson. Boston, Little, Brown, 1979. 450 p. \$17.50.

**Sex and Gender: The Transsexual Experiment:** Robert J. Stoller. New York, Jason Aronson, 1975. \$20.00.

## GYNECOLOGY

**Cancer of the Breast:** John S. Spratt and William L. Donegan. 2nd ed. Philadelphia, Saunders, 1979. 701 p. (Major problems in clinical surgery, v. 5).

**Manual of Gynecologic and Obstetric Emergencies:** Ben-Zion Taber. Philadelphia, Saunders, 1979. 929 p. \$24.50.

**Novak's Gynecologic and Obstetric Pathology:** Edmund R. Novak and J. Donald Woodruff. Philadelphia, Saunders, 1979. 795 p. \$30.00.

## DERMATOLOGY

**Dermatology in General Medicine:** Thomas B. Fitzpatrick, ed. 2nd ed. New York, McGraw-Hill, 1979. 1884 p. \$85.00.

**Histologic Diagnosis of Inflammatory Skin Diseases: A Method By Pattern Analysis.** Philadelphia, Lea & Febiger, 1978. 863 p. \$84.50.

## Denver Doctor Takes Part in War Games

Theodore R. Sadler, Jr., MD, Denver surgeon, who is a Brigadier General in the Army Reserve medical corps, in command of the 2nd Hospital Center at Hamilton Field, California, will participate in a major military exercise in Germany during March 1980.

Dr. Sadler, a cardio-vascular surgeon, is on the surgical staff at St. Joseph Hospital, Denver, and has a surgical practice in Denver.

## Johnson Named to Conference Faculty

Michael L. Johnson, MD, of the University of Colorado Health Sciences Center has been named to the faculty of the Fifth Annual International Body Imaging Conference to be held at the Kauai Surf Hotel, Kauai, Hawaii, October 11 through 19, 1980.

## 9 HEALTH FAIR

**STATEWIDE HEALTH FAIR  
APRIL 13-20, 1980**

Plans for the 9 HEALTH FAIR are well under way, but it is not too late for communities or individuals to get involved. Anyone interested in finding out more about the HEALTH FAIR is invited to write to 9 HEALTH FAIR, Box 5667, Denver, 80217, or call (303) 893-4455.



# at press time ...

## CMS LEGISLATIVE HOTLINE AGAIN IN OPERATION

The "Legislative Hotline" is again in operation and will be updated, according to the activity at the Capitol. We urge all Public Policy Chairmen, KeyMen, Specialty Society Chairmen, and Component Society Executives to use the "hotline" on a regular basis (832-9527). Members are encouraged to take advantage of the mechanism which makes it possible for messages to be left at the end of the hotline message, an excellent tool which which individual input can be made.

Questions concerning federal or state legislative matters not included on the hotline should be directed to the Government Affairs Division. Call Carol Tempest or Lorraine Koehn at 861-1221, Ex. 277 or WATS 1-800-332-4150.

The Government Affairs Division receives on a daily basis state legislative calendar and journals, and can provide information on committee hearings, the status of bills on any particular day and any other needed information on schedules.

The Division itself also monitors the Congressional Record and the Federal Register, the former with its verbatim account of happenings in Congress, and the latter with all proposed rules and regulations, as well as notices of federal grants and national regulatory meetings. Those who are interested in a particular bill, a proposed regulation, or statement made by a Congressman should call this CMS Government Affairs Division.

## COLORADO FOUNDATION FOR MEDICAL CARE REQUESTS PHYSICIANS' ASSISTANCE

During the last several months, Colorado physicians have been using a variety of sources of diagnostic and procedural codes in billing for ambulatory services. The Ambulatory Peer Review Program of the Colorado Foundation for Medical Care, in the interest of serving both the patient and the physician more efficiently, is requesting that physicians indicate the source of the diagnostic code (ICDA, HICDA, ICD-9-CM, DSM-II) or the source of the procedural code (CRVS, CPT, BC/BS Physicians' Manual), on each claim form to assure correct and timely processing of each claim. The few seconds it will take to note the source of the diagnostic or procedural code on each claim will facilitate the Foundation's peer review process, and reduce inconvenience caused when Foundation personnel incorrectly determine the coding source used.

In addition, please note that the conversion factors currently utilized in Colorado Foundation Ambulatory Peer Review contracts apply only to the CRVS and do not apply to the BC/BS Physicians' Manual.

## ALUMNI RECEPTION PLANNED

Alumni of the University of Colorado School of Medicine will be honored by a reception to be held on Saturday, March 1 at Writers' Manor, in the Somerset Room from 7 to 9 pm. There will be an opportunity to meet the new Dean, M. Roy Schwarz. Call Cynthia Nail, 394-8832 for further details.

## SPECIAL FOR OFFICE MANAGEMENT - ICD-9-CM CODING CLINIC

The Commission on Professional and Hospital Activities is sponsoring a one day ICD-9-CM Coding Clinic in Denver on February 26, 1980. This is a combination refresher course and problem-solving session designed for medical office personnel already familiar with ICD-9-CM coding who wish to improve their skills. Up-to-date answers to a number of current coding problems like coding postoperative complications or obstetrics. For registration and information, call CPHA toll-free at 1-800-521-6210.

## AMA PUBLICATIONS A BOOST TO FAMILY HEALTH

These attractively designed publications are planned to provide such special information as a patient might need to set up an exercise program, a diet, or to comprehend alcoholism, or to be informed about the dangers of smoking. To receive a set of these publications, write: James H. Sammons, MD, Executive Vice President, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

## THE CORRECTIONS COMMITTEE OF THE COLORADO MEDICAL SOCIETY MEETS AT PEN

The Committee on Medical Care in Correctional Institutions, headed by John V. Buglewicz, M.D., Florence, Colorado, met on Friday, February 1, 1980, at Colorado State Penitentiary. Committee members have been consulting with health care service facilities in the new maximum security section now under construction. Staff members of Colorado Medical Society also were on hand to tour the infirmary at "Old Max". (See pictures in magazine centerfold.)

Colorado Medical Society Board of Trustees, at their January meeting, approved the funding of \$4,700.00 for participation in the AMA/LEAA Jail Program. This study will target ten county jails in Colorado to assess the level of medical care afforded inmates. In all, the jail study will be financed to an approximate level of \$39,000.00 with the combination of CMS, AMA and LEAA funding.

The Society's Corrections Committee feels that such a study will possibly prevent necessity of further litigation, as has been the case at the Colorado State Penitentiary.

The penitentiary generates some 56,000 record entries each year, all of which are hand entries in the bulky records file system. Members of the committee agree that this system severely hampers quality medical care for the some 1,500 inmates. A full report on the committee's proposals to the Colorado Department of Corrections concerning health care services in correctional institutions will be published in the MARCH issue of COLORADO MEDICINE.

Dr. Buglewicz, in discussion with prison officials, proposed a program of utilization of local medical personnel and family practice residents in southern Colorado to upgrade medical treatment as well as necessary surgical practice, under the supervision of practicing surgeons at state institutions (Colorado State Hospital, Pueblo). Dr. Buglewicz added that his committee would work to detail such a plan in the March report.



## CORRECTIONS COMMITTEE (Continued).....

Although the plans are very much in the formulative stages, the committee has, thus far, worked out some seemingly practical solutions to improved health care and medical treatment services for the penitentiary. Chief among these is the proposal by both committee members and the medical staff at the penitentiary to incorporate the family practice resident physicians in Pueblo. Dr. Buglewicz and Robert Moore agreed that local professionals should be utilized, whenever possible, to provide medical services to prison inmates; however, this creates another serious problem and cost in having to provide security for these inmate-patients when transferred to local facilities. St. Thomas Moore hospital in Canon City is far enough removed from the penitentiary that transfer of patients for necessary treatment and surgery would be expensive and troublesome.

Instead of this, Dr. Buglewicz recommends that Family Practice Residents in Pueblo, a part of the medical education program of the A.F. Williams Family Practice Center, University of Colorado School of Medicine, be given the opportunity to aid in inmate treatment. This, Dr. Buglewicz says, could be a regular, required part of their residency program, wherein each resident would fulfill a three-month resident practice program at Colorado State Penitentiary. All of these residents, Dr. Buglewicz points out, would like the opportunity to perform surgery during their residency. The plan includes the use of the facilities, already in place, at Colorado State Hospital for surgical cases, where an attendant surgeon could oversee each such operation. This, he adds, would be very cost-effective for the prison, the school and the hospital, while providing a wealth of experience for the resident both in surgery and in patient treatment in the prison infirmary.

Another aspect of the plans being discussed by the Medical Corrections Committee is the development of a medical records system. Such a system, to be effective today, must incorporate a computerized program tying all penal and correctional facilities in Colorado together. Both the prison authorities and committee members see that such a data base for all records-keeping and billing procedures is already in existence. Colorado Foundation for Medical Care is already in operation of the most up-to-date PSRO program, with an excellent state-wide review system and data collection base. The Committee's proposal would involve procurement of funds, through a grant or some such mechanism, to build a program for the penitentiary records, provide the necessary computer hard- and software to use existing ICD-9-CM codes, and interface this program with the existing Foundation system. The committee members also see that this system could go state-wide, incorporating all city and county jails, detention and correction facilities and reformatories, thereby providing a record base for any person who has entered the correctional system from this point forward. The system would allow for the transfer of any previous recorded medical information to be available within a matter of hours, rather than days or weeks, thereby giving the same standards of quality care to institution inmates as to the general public.

Dr. John Buglewicz and Medical Services Director Bob Moore point out that the plan is in a very early stage of development, but the logic of such a review program would seem to provide the best answer for that needed assurance of quality care for all state correctional institution inmates.

## CMS/DMS TV PROGRAM WINS STATE AWARD

"MEDICALINE", the half-hour program which has had a successful run on KMGH-Denver, for five years, this year was recognized by the Colorado Broadcasters Association at their winter meeting in Denver. "MEDICALINE", jointly produced by University of Colorado School of Medicine, Colorado and Denver Medical Societies and KMGH-TV, was awarded second place in "continuing television public service series" programs. The program is aired, live with taped portions, once monthly in prime-time Sunday evening schedules by KMGH McGraw-Hill. Host of the program is Roger Hamstra, M.D., Associate Professor of Medicine, Department of Medicine, UCHSC.

David Johansen of the University's Department of Educational Services and Bob Hahn, Assistant Administrator and Director of Communications, Denver Medical Society, have also been active in producing the program.

John Stretts, Director, has faithfully steered the program throughout its entire on-air lifetime.

COLORADO MEDICINE congratulates the award-winning program and team which have provided Coloradans with excellent, first-hand health care information throughout these years.

## SHIRLEY MYERS NAMED 'INTERNIST OF THE YEAR'

The Colorado Society of Internal Medicine, at its annual meeting at Colorado Springs, presented the Internist Of The Year award to Shirlee Myers, Executive Director of the Colorado Academy of Family Physicians.

Shirlee edited the Directory of Physicians for ten years, not to mention the fact that she was an employee of the Colorado Medical Society for a total of 21 years, during which she believes she handled about every job in the organization. Today, Shirlee is a wealth of possible programs and projects, and provides CMS staff with excellent resources for further aiding the specialty groups.

**Physicians' average net income** rose 5.3% per year in the period 1970-1978, less than the 6.7% average yearly increase for all goods and services as measured by the Consumer Price Index. The percentage growth in physicians' average net income was 2.9 in both 1977 and 1978, while the CPI's all items was 6.5% in 1977 and 7.7% in 1978. These figures are contained in the 1979 edition of *Profile of Medical Practice* (the "Red Book"), published by the AMA's Center for Health Services Research and Development. The book contains research articles on medical economics and data which profile physician work patterns, fees, expenses, and incomes by specialty, age, census division, size of practice and location. For more information contact the Center, AMA Headquarters.

**Model legislation defining death** has been forwarded by the AMA to state medical associations. The model act states that an individual who has sustained irreversible cessation of circulatory and respiratory

functions or irreversible cessation of functioning of the entire brain is to be considered dead, and that determination of death by a physician is to be made only in accordance with accepted medical standards. The model bill was adopted by the House of Delegates a year ago and was amended at the 1979 Interim Meeting. Legislation concerning brain death has been adopted by 25 states.

**The AMA continues its support** for educational efforts to curb drug abuse in athletics and to cooperate fully with sports governing bodies which have outlawed the secret use of stimulatory drugs among athletes. At the 1979 Interim Meeting the House of Delegates said the AMA will emphasize to the public and the medical profession that there "is no valid scientific evidence that any drug has ever resulted in improved athletic performance." The House said drugs of any type should be used only under strict medical supervision for the treatment of disease, deficiency, or injury.



**LARIMER COUNTY MEDICAL SOCIETY**

**PRESIDENT**

Richard L. Codd, MD  
1217 E. Elizabeth  
Fort Collins, Colorado 80524  
482-9662

**SECRETARY/TREASURER**

Peter J. Standard, MD  
1032 Luke  
Fort Collins, Colorado 80524  
221-1205

**MOUNT SOPRIS COUNTY MEDICAL SOCIETY**

**PRESIDENT**

R. Douglas Yajko, MD  
2001 Blake Avenue  
Glenwood Springs, Colorado 81601  
945-6533

**SECRETARY/TREASURER**

Richard A. Herrington, MD  
366 State Highway 133  
Carbondale, Colorado 81623  
963-3350

**NORTHEAST COLORADO MEDICAL SOCIETY**

**PRESIDENT**

Michael D. Hostetler, MD  
P.O. Box 9058  
Steamboat Springs, Colorado 80477  
879-3327

**SECRETARY/TREASURER**

Richard T. Batts, MD  
Routt Memorial Hospital  
Steamboat Springs, Colorado 80477  
879-1322

**LA PLATA COUNTY MEDICAL SOCIETY**

**PRESIDENT**

T. W. Halley, MD  
P.O. Box 2637  
Durango, Colorado 81301  
247-2611

**SECRETARY/TREASURER**

Martin P. Pirnat, MD  
P.O. Box 2637  
Durango, Colorado 81301  
247-2611

**DELTA COUNTY MEDICAL SOCIETY**

**PRESIDENT**

Adolfo J. Torrez, Jr., MD  
361 Palmer  
Delta, Colorado 81416  
874-4473

**EXECUTIVE SECRETARY**

Marion Austin  
1690 Stafford Lane  
Delta, Colorado 81416  
874-7681, ext. 203

**LAS ANIMAS COUNTY MEDICAL SOCIETY**

**PRESIDENT**

Guilebaldo E. Jimenez, MD  
First National Bank Building  
Trinidad, Colorado 81082  
846-7787

**SECRETARY/TREASURER**

Stanley H. Biber, MD  
First National Bank Building  
Trinidad, Colorado 81082  
846-7787

**SAN LUIS VALLEY MEDICAL SOCIETY**

**PRESIDENT**

Burt R. Erickson, MD  
1847 2nd  
Alamosa, Colorado 81101  
589-6605

**SECRETARY/TREASURER**

Albert Duncan, MD  
1847 2nd  
Alamosa, Colorado 81101

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**Physician Location Office Moved**

The Colorado Medical Society Physician Location office is now in the Division of Socio-Economics and Medical Services, as a responsibility of its Director, Robert Fitzgerald and his secretary, Sandy Went. It will be linked to a statewide system developed by Dr. S. Jack Locke and the Office of Rural Health. Future computerization within CMS is anticipated.

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# ama update

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It is unfortunate that we live in a time of such negative influences bearing on the very positive nature of the practice of medicine, but it is true. Why should these influences continue to have a bearing on a profession that is, to all intentions, for the good of mankind? The reasons are countless; among them, the goliath known as government, the multitudinous federal, state and local regulations, the overlapping and pyramiding health and medical care programs for the very young, the very old, the indigent, the low and fixed income person or family, and on and on.

I am not about to say that these regulations and these programs are all bad. What I am saying is that if these programs and regulations are to exist, and exist they must, they must not be allowed to exist without the day-to-day attention by members of the medical profession. Regulations and programs are good, provided they can be created and administered in a realistic, scientific, and ethical manner. How can we assure ourselves and other members of our profession that this will happen? Only by an organized professional front consisting of physicians who are willing to give of their time and their knowledge to see that such regulations and programs are realistic in their goals and their mechanisms, scientific in their application through proven medical practice, and ethical in their treatment of the affected public AND the participating physicians. That one organized front which is made up of professionals is the American Medical Association.

There is no alternative to the AMA. Some group interested in the doctor and the patient has to work for what is best and develop the resource and manpower to do all this.

The AMA can work for your interests only by having your interest expressed in the AMA. That is why I write you now: to seek your active support for the best process we have of making our unified, professional medical voice heard across the land. The AMA can do this only with your support. Colorado Medical Society cannot do the job; your component society or specialty group cannot do the job. With your help, the American Medical Association can!

Many of the members of AMA are passive members, while others who do not belong have attitudes about the AMA which are left over from years past, from "hard line" positions taken in earlier years by the organization. Today's AMA is a young, aggressive, politically aware organization, but it can't do the job without the help of every physician in the country.

Negativism in our profession can have serious effects, and our best, unified defense of this influence is the AMA. Colorado Medical Society is launching a program to enlist the aid and the participation of as many of our members as possible. None of us can afford the luxury of non-participating any longer. You are already benefiting from the AMA. If you can acknowledge that, join us!

Robert E. McCurdy, MD  
Senior Delegate to AMA

## CMS MOURNS LOSS OF LONG-TIME MEMBER



### S.O. ELSE

The Medical Society was saddened to learn this week of the death of one of our medical community's most valuable members, Someone Else. Someone's passing creates a vacancy that will be difficult to fill. Else has been with us for many years and for every one of those years, Someone did far more than a normal person's share of the work.

Whenever leadership was mentioned, this wonderful person was looked to for inspiration as well as results: "Someone Else can work with that group." Whenever there was a job to do, a resident to teach, a meeting to attend, one name was on everyone's lists — "Let Someone Else do it." It was common knowledge that Someone Else was always the one who was happy to see the unfortunate patient with no income or insurance. Whenever the society was called upon to support a charitable or community project, everyone just assumed that Someone Else would provide what was needed. Someone Else was a wonderful person — sometimes appearing superhuman, but a person can only do so much. Were the truth known, everybody expected too much of Someone Else. Now Someone Else is gone! We wonder what we are going to do? Someone Else left a wonderful example to follow, but WHO is going to follow it? Who is going to do the things Someone Else did? When you have a chance to participate in the society activities REMEMBER — we can't depend on Someone Else anymore.

*Now that Someone Else is no longer available . . .*

perhaps you would like to become involved in the activities of your County Medical Society. You can make the decision right now to participate actively, not just pay dues and have no say.



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## president's letter

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This month finds us well into another session of the Colorado General Assembly; in January the political arena became heated as never before at the Capitol. We, as medical professionals have as much vested interest in the issues before the lawmakers as Colorado has ever seen in any session.



Among the foremost questions are the nurse practice act, the legislation for medically indigent of rural and urban Colorado, proposed continuation of the Colorado Hospital Commission, the question of salary limits for state-employed physicians and other issues. Of course, Colorado Medical Society's Committee on Medical Care in Correctional Institutions has been heavily involved with the State Department of Corrections to work out feasible plans for proper health care services to inmates. These meetings and planning sessions will continue, but the day-to-day work before the legislature is of concern to every person in the Colorado health care service community.

My purpose this month is to urge each person reading this letter to participate, to contribute to the reservoir of ideas which the legislature needs to make effective, worthwhile decisions for the benefit of ALL Coloradans. Medically indigent legislation is vital to satisfy the needs of Denver's burgeoning growth as well as the health needs of rural Colorado. Your input as a professional is just as vital.

Exchange of information between physicians and health care personnel is equally as important as the exchange between legislator and doctor. I urge all of you in Colorado Medical Society actively to pursue communications with nurses and parimedical personnel. Equally, though we may not be directly concerned, we must help in assimilating the information and guidelines for health legislation.

Placing a person or group of persons into a responsible, decision-making office or position is not the end of the political process. We each must contribute to that person or group's doing an effective job for all the people they serve. It is up to you, as individuals, to recognize your continuing responsibility to this process, for your welfare and the welfare of all Colorado.

Incidentally, I am sure you share with me my enthusiasm for the excellent format and appearance of this new *Colorado Medicine*.

It exceeded all my expectations, and I think you are appreciative, as I am, of the efforts of the staff. I would recommend that you save this first copy. It will certainly be a collector's item.

*Ray S. W. Peterson*

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## executive report

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In lieu of a report from the EVP, here follows a report on the EVP:



The first day Jerry Bowman arrived at the Colorado Medical Society there was enough snow to lose a Cadillac. That showed him one of many differences between San Diego and Colorado.

During the first learning period in his new office (Executive Vice President, the Colorado Medical Society and the Colorado Foundation for Medical Care) Jerry, whose last name rhymes with plowman, is intent on discovering what it is that makes Colorado different from California, in terms of people, policies, and organization.

Though he has packed in ten years' experience as Assistant to the Executive Secretary of the California Medical Association, and eleven years as Executive Director of the San Diego Medical Society, Jerry believes he will really discover how to get "from here to there" when he gets to know the individuals and their stands.

When he can say, "Hey, let's do some new things, let's slaughter some sacred cows - maybe we can learn" Jerry feels he will have reached a point of departure, at which things will jell, and movement and improvement will take over.

The personal factor in organizational relationships has always been keyed to Jerry's approach to his work.

As a child he adapted to numerous situations, moving when he was six from his native Vandergrift, Pennsylvania to Chillicothe, Ohio, and then in his early teens to Redlands, California, where he was raised by his great-grandparents. After finishing high school there, Jerry Bowman attended a junior college in the San Francisco Bay area, then went on to the University of California at Berkeley where he was graduated in 1954 with a BA in Psychology.

Application of this approach to behavior and emotional attitudes in the Army Quartermaster Corps and to an Army pipeline outfit was not altogether rewarding though it did take him to Okinawa and broadening experiences.

Out of the Army, Jerry moved to the Bank of America in San Francisco where he developed longitudinal studies on bank employees, and found that the president of the bank was encouraging his practical application of psychological principles in the development of counseling services. Jerry worked directly with the president in assembling resumes, and in establishing hiring practices as well as performance and retention programs.

Mostly, he recalls, he "packaged executives for employment."

After three years, Jerry moved to the California Medical Association to become assistant to the Executive Director. He received training from the CMA staff in personnel policies which he developed with eventual improvement in all internal operations, including personnel, accounting, membership, and office services.

"California takes extremes into a mechanism that compromises, and this is where we want to go. Colorado is willing to learn. Its concerns have put it behind California's handling of similar issues. But then, for instance, Colorado has not yet had a severe malpractice crisis. Million dollar judgments are handed down every week or so out there."

After ten years with CMA, Jerry came to believe he was "butting his head on the ceiling," sought new terrain, and ended up as Executive Director of the San Diego Medical Society.

San Diego showed a "posture of great growth, but there was a major malpractice crisis just as I arrived, and I was able to produce an approach to this and to other problems involved in immense society growth that turned the San Diego society around."

San Diego was isolated between the Pacific, Mexico, and the desert, but it has become the medical center of California because of climate, geography, and the quality of its population.

"The cohesiveness it has developed, a growth in membership from 1968 to 1978 of 1400 to 2200,

and a growth in budget from \$200,000 to over \$1 million, reflect a Society that had "the style or the charisma or chutzpa that seemed to bring everyone to San Diego to learn how to do it - it was always a fish bowl."

"When I arrived there I didn't know what a county society did, but there was a great bunch of people who let me learn, and I was then able to set a tone, and through good teamwork the Society grew in strength and stature, and even managed to build an outstanding functional and handsome new building for the Society."

Though a conservative society, it was "not so hard to lobby things through."

Jerry had married Sandra, a physical therapist, and after the three children were raised, she took up a third career in food management, and now is the assistant manager of one of San Diego's fine restaurants. Three years ago she had taken over management of the San Diego Medical Society's cafeteria, as well as of its distinguished, in-house French restaurant, and of the meeting rooms at the offices.

The youngest of the three, Tod, is a high school freshman, still in San Diego, and the middle, the girl Bree, is a freshman at Scripps College, Claremont, California, and the eldest, Matt, is a student at the Universal Institute of Technology, Phoenix, Arizona.

Jerry's hobbies are music, food, and wine. He has a fondness for music that goes back to when he was six or so and a favorite aunt asked him what gift he would like. Without hesitating, he told her he would like to have a record of Brahms' Hungarian Rhapsody, Number 6. His deep-seated affection for good music provides him with release from the tensions of hard work. Jerry has played some classical guitar. He is intrigued by food and wine, and cooks and also prizes a California Cabernet he made several years ago.

As he looks about to consider what he has already learned in Colorado, Jerry sees all kinds of things that need to be done. He hopes to develop a system that would resemble a wheel, with CMS at the hub, the component societies at the spokes, staff firming up activities to make a rim on which the wheel would turn with as few problems as possible.

"I need time," he continues, "but within six months I hope we will have a harmonious atmosphere in which to work. In a second stage, I hope to work with the Society leadership to find out where it truly wants to go, and in a third, I want to start meeting with the allied health people, the legislature, the business community.

"I'm anxious to get out into the community, to meet the makers and shakers, but I can't do it just being in the box."

**Allen Young**  
Assistant Editor



# DMS Studies Four Health Areas

Among the numerous committees of the Denver Medical Society, four are currently studying fascinating contemporary health areas. They are the Holistic Health Task Force, the Special Committee on Mental Health, the Committee on Child Abuse and Neglect and the Public General Hospitals Task Force.

The Holistic Health Task Force was formed in view of the increasing public awareness of the holistic health movement and the rising media interest in the method of approach to health being employed by some of the groups. It is hoped that the study might result in a position which the Denver Medical Society could take regarding "holistic health care" as seen in the Denver area, as well as the discernment of its positive and negative elements. A membership meeting, called "Constituency Nights", is being planned for an open discussion of this subject this year.

The Public General Hospitals Task Force was established in the Spring of 1979 to examine the relationship between the medical community, as represented by DMS, and the public hospitals, specifically University Hospitals and Denver General Hospital. The basic mission is to enhance the complementary relationship between the public and private sectors.

The Special Committee on Mental Health is the body within the Society dealing with both private and public services and facilities providing mental health care. This year, it is addressing itself to the

needs of the chronically mental ill patients and their families. Augmenting the physician membership of this Committee are persons representing disciplines other than medicine, who are involved in the care of such patients. The Committee is also charged with keeping the Society informed regarding legislation on this subject and, when appropriate, making recommendations for a Society legislative position.

A revision of the DMS instructions to its members for the reporting of child abuse and neglect has been completed by the committee charged with this area of study. This committee is also augmented by persons from the community dealing with this area. The revised set of instructions will be disseminated to all DMS members soon. It is also included in the DMS New Member Handbook.

The directions include eight sections:

1. Professionals Mandated to Report Child Abuse and Neglect in Colorado
2. Legal Definitions of Child Abuse and Neglect in Colorado
3. Reporting Mechanisms
4. Protection of those Reporting
5. Penalties and Risks of Not Reporting
6. Consultations on Child Abuse Cases
7. Investigations Mandated by Report
8. When to Call Police

These Task Forces and Committees report to the Commission on Public Health of the Denver Medical Society.

## Certificate of Service and Robins Award

The deadline for receipt of nominations for the Colorado Medical Society's *Certificate of Service Award* and the *Annual Robins Award* is June 15, 1980.

The Certificate of Service is the highest award given by the Medical Society to a physician "for outstanding contribution to the Constitutional purposes of the Society."

The purpose of the Robins Award is to honor a physician in our state "for outstanding COMMUNITY SERVICE."

Send nominations to the Confidential Awards Committee, 1601 E. 19th Ave., Denver 80218. These awards will be presented during the Colorado Medical Society's Annual Session, September 24-27, 1980, at The Broadmoor.

# RADIATION:

## WHAT DO WE KNOW ABOUT IT?\*

R. W. Bistline, PhD., R. E. Yoder, ScD., and D. C. Hunt, PhD., Golden, Colorado

We are living in a time when great public and professional concern is being voiced with considerable discussion taking place regarding the health effects of ionizing radiation on our human race.

Initially these concerns focused on what we now consider high levels of radiation exposure. However, with the growth of the nuclear age — the use of nuclear medical technics, nuclear energy, nuclear weapons, etc. — greater and greater concerns are being voiced over the possible effects of exposure to even very low levels of radiation.

Numerous reasons for these concerns can be cited. These include honest attempts to estimate the effects of low level exposures from data on high levels, misunderstandings, media interpretations, wrong information, the tendency of professionals to make the discussions highly technical, and the widespread lack of information.

The word "radiation" alone tends to engender in the minds of the lay public, an image of a large mushroom cloud, excess cancer incidence, and mutated individuals. With this in mind, this article provides a look at the amount of information known and considered by experts in determining radiation health risks and establishing radiation protection standards.

In 1895, Wilhelm Roentgen observed that X-rays would expose photographic film, which led to the widespread use of X-rays in medical diagnosis. Before long it was found that like so many physical and chemical agents in our lives, too much radiation was harmful. In 1903, the *New England Journal of Medicine* reported that mice exposed to large doses of X-rays soon died.

With the expanded use of radiation and radioisotopes by doctors, dentists, radiologists, and researchers, it was observed that many of these people developed malignancies of the skin and leukemia. By the 1920's, genetic changes in insects were observed and there grew some suspicion of developmental defects in infants whose mothers

had been heavily exposed to radiation.

As a result of these concerns for the effects observed, two radiation protection agencies were organized in the 1920's. The International Congress of Radiology formed the International Commission on Radiological Protection (ICRP) and the American counterpart, the National Council on Radiation Protection and Measurements (NCRP). These groups consistently have been comprised of some of the world's most prominent medical doctors and radiation researchers.

Following World War II, the nuclear age grew, and more knowledge of radiation effects on people was accumulated.<sup>1</sup> Literally billions of dollars were spent on research to answer the increasing numbers of questions regarding biological effects on radiation. Extensive studies were, and continue to be, carried out on laboratory animals and exposed human populations.

These populations include persons receiving radio-therapy for a variety of disease conditions,<sup>2 3</sup> Japanese atom bomb survivors,<sup>4</sup> occupationally exposed persons such as radium watch-dial painters,<sup>5</sup> radiologists, uranium miners,<sup>2 6</sup> nuclear industry workers<sup>7 8</sup> and populations living in high naturally occurring background radiation areas.<sup>9 10</sup>

As a result, it is said that we know more and have spent more money on research of radiation exposure and its effects than any other physical or chemical agent. The ICRP and NCRP have proceeded to publish volumes of recommended occupational guidelines based upon the review of all the studies and research available over the past 50-plus years.<sup>11 12</sup>

As time passed, it became apparent that permissible guidelines for the general public exposure to radiation were also needed. The National Academy of Sciences formed a committee on the Biological Effects of Ionizing Radiation (BEIR), and the United Nations established the Scientific Committee on the Effects of Atomic Radiation (UNSCEAR). These groups have been comprised of outstanding and internationally recognized radiological and medical experts to review the literature and assess health risks. These groups have reviewed animal and

\* Drs. Bistline, Yoder, and Hunt are in the Department of Health, Safety, and Environment of Rockwell International at the Rocky Flats Plant.



human studies and have considered all of the appropriate parameters in developing the most realistically conservative approach to health risk assessment.

Some considerations useful to these groups in their radiation risk evaluations are now being reviewed. Animal experiments have shown that protracting a radiation exposure reduces the probability of tumor development.<sup>13</sup> Human studies of radiation effects on Japanese atom bomb survivors and those persons treated with radiation for Ankylosing Spondylitis, among others, have provided important and reliable data for developing risk estimates.

These studies have included sizeable human populations from the United States, Europe, Japan and elsewhere.<sup>2 3</sup> These studies also have shown that no statistically significant, detectable effects can be demonstrated in persons having been exposed to low dose-rate radiation similar to that experienced in the operation of nuclear facilities.<sup>2 4 13</sup>

Edward Webster of Harvard Medical School has studied the atom bomb survivor data and a number of other exposed populations (such as groups of radiologists, X-ray technicians, and women treated with radiation for cervical cancer). Webster showed the risk of cancer in the Nagasaki data falls to at least half of that expected from linear extrapolation from higher dose effects; the other groups showed no excess of cancer.

In the early years following World War II, when little was known about the carcinogenic risks of radiation, genetic effects were considered to be more hazardous. The situation is now known to be

reversed, i.e., the cancer risks are greater and the genetic risks less than previously thought. In fact, animal studies carried out over many generations, with exposures of 200 rem per generation, show no apparent change in fertility or any evidence of poor health. Studies of the descendants of Japanese survivors of the atomic bombings also show no evidence of genetic effects from the radiation exposure.<sup>2 13 14</sup>

The exhaustive review of all of the many varied human exposure groups have been compared with the thousands of animal research studies.<sup>15</sup> These data have been used by the ICRP, NCRP, BEIR, and UNSCEAR committees to publish their best opinions and interpretations. There is still an absence of complete agreement about the interpretation of the data as evidenced by the minority report submitted with the BEIR III report to the National Academy of Sciences.<sup>16</sup> Safety reduction factors have intentionally been added to the data for establishing their occupational and population standards, guidelines, and risk assessments. These groups continue to review data year after year and issue updated opinions and findings as evidenced by the BEIR I (1972), BEIR II (1977), BEIR III (1979), and UNSCEAR (1958, 1962, 1964, 1966, 1969, 1972, 1977) reports.<sup>16 17</sup>

We will be submitting further articles on (1) the application of these radiation protection guidelines and risk estimate techniques, (2) important specific researches on health effects, (3) influencing factors and considerations, and (4) the environmental and epidemiological studies, past and present. ●

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# CFMC STUDIES CT HEAD SCAN

The opportunity of demonstrating the real effectiveness of CT Head Scanning by analysis of well documented CT applications to clinical problems is now present through the Medical Care Evaluations Study Program of the Colorado Foundation for Medical Care, according to Paul Wexler, MD, Associate Medical Director of the Program.

Computerized axial-tomography or the CT Scanner is changing the diagnostic approach to many medical problems, especially in the area of neurology and neurosurgery. The CT Scan has been demonstrated to be a non-invasive, low risk procedure which is remarkable effective in diagnosing diseases which previously required the use of hazardous and invasive diagnostic techniques, and thus has been rapidly accepted by the medical community.

Dr. Wexler, who prior to joining the Foundation in 1977 worked actively with Medical Care Evaluation Studies at Rose Medical Center, and who continues as Chief of OB/GYN at the Center, hopes that assessment of information gained from CT Head Scanning will lead to increasingly valuable guidelines. The current guidelines were established in 1977, and have been revised annually since then. In addition, the study may make it possible to assess the manner in which information gained from CT Head Scan effects utilization and sequence of other diagnostic procedures.

The great expense of CT Scanning has given rise to tremendous concern about cost implications of its widespread use. Health insurance companies and governmental agencies involved in the finance and planning of health care have advocated controls on use of CT Scanning. In some instances their approach has centered

upon cost control without any consideration of the state of the art of proven diagnostic benefits to the patient.

The director of the study is Charles Siebert, MD, head of Neuroradiology at Swedish Medical Center, which was the first Colorado hospital to obtain a CT scanner. Dr. Siebert represents the Colorado Radiological Society to the CFMC Health Care Standards Committee.

In the current phase of the study Dr. Siebert has solicited participation in the study from providers in Colorado who operate CT Scanners, including 15 hospitals and three physician groups. Data collection is scheduled to begin by the second week of March 1980. It is hoped that this study will lay the foundation for future studies on the appropriate use and cost benefit of CT technology. The key to the study's success will be widespread participation which will provide the broadest possible baseline.

Chairman of the CT Scan Criteria Subcommittee since 1977 is James Karel, MD, an internist who has been a member of the CFMC Health Care Standards Committee since its inception. He has chaired the Committee, composed of neurologists, neurosurgeons, and radiologists which developed the initial CT Scan guidelines and which, since 1977, has been responsible for annual guidelines revisions.

Dr. Karel has observed that expertise in developing guidelines for any diagnostic procedure can come only from the practicing medical community, motivated by a deep concern for the patient's welfare, and for the most effective way to finance medical care.

It is through such studies that the Foundation aims to provide practicing physicians with the opportunity to control the destiny of the health care process.

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## INACTIVE LICENSURE STATUS NOW AVAILABLE FOR COLORADO PHYSICIANS

Physicians not in active practice in Colorado can now retain their licenses without meeting the annual continuing education requirements of the Board of Medical Examiners.

Request for inactive status is made in writing, and may be submitted as part of the licensure renewal application form. The new regulations also specify procedures for reactivating licensure. Details are available from the Board of Medical Examiners, or from Kevin Bunnell, Director, Division of Continuing Education, Colorado Medical Society, at 861-1221 x 262 (or toll-free outside the metropolitan Denver area at 1-800-332-4150 x 262).





At the far end, President Ray G. Witham oversees the annual meeting of the Board of Trustees of the Colorado Medical Society.

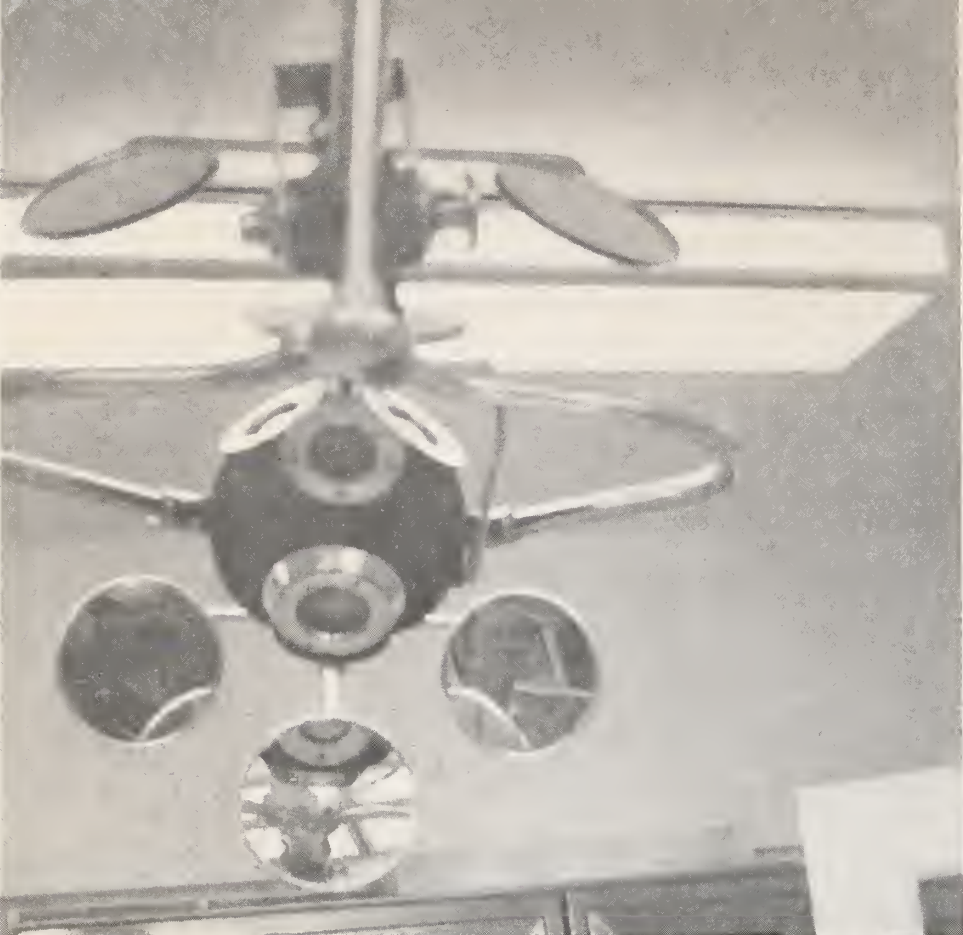


Jerry J. Appelbaum, center, attends to the business at hand. At his right is Betsy Becker, President of the Auxiliary, with William Jobe at his left, and K. Mason Howard in the right foreground.

At the far end of the table is Larry Wood, Legal Counsel to the Board of Trustees of the Colorado Medical Society, with K. Mason Howard, President-elect at his left, Richard F. Bedell, Abraham J. Kauvar, Wilfred Stedman, James R. Brusenhan, and David Bates of Greeley, from left to right.







If you can identify the octopus-like device in the picture at left, you're either an antique buff, or have been in the practice of medicine a numberrrrr of years. The device is the surgical lamp with its attendant system of mirrors, still in use at the Infirmary of the Colorado State Penitentiary. This antique, like the rest of the infirmary is in excellent working order and repair; however, it is typical of the added difficulties placed on a health-care delivery system that works in the deep confines of the penitentiary maximum security unit of Colorado State Penitentiary. These facilities, pictured here in brief, were the focal point of the February 1st meeting of the CMS Committee on Medical Care in Correctional Institutions.

John Buglewicz, Corrections Medicine Committee Chairman, discusses the CSP Infirmary facilities with Colorado Medical Staff members and prison officials.

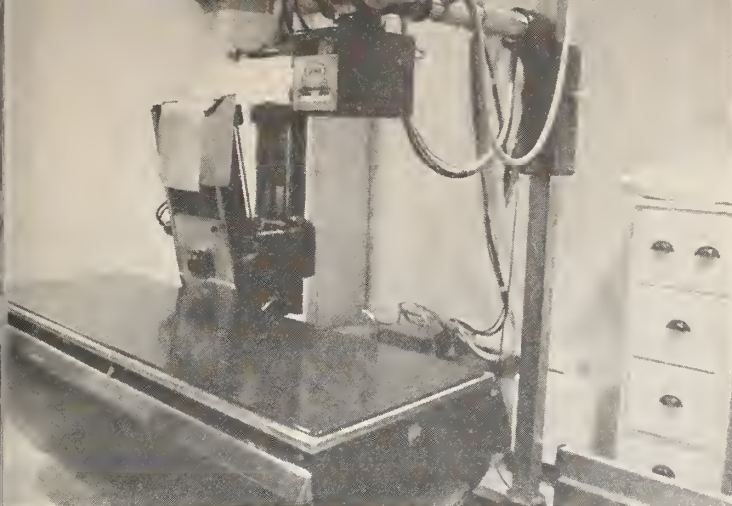
L to R: Robert FitzGerald, J.D., of the Council on Socio-Economics, George S. Williams, M.D., John Buglewicz, M.D., and Sandy Went, of the Socio-Ec staff.

In discussions with Bob Moore, Director of Prison Medical Services, and Edna Reilly, Director of Nursing at the penitentiary, Committee Chairman John Buglewicz, M.D., Florence, Colorado, learned that a primary difficulty in the system is the lack of an efficient medical records program.

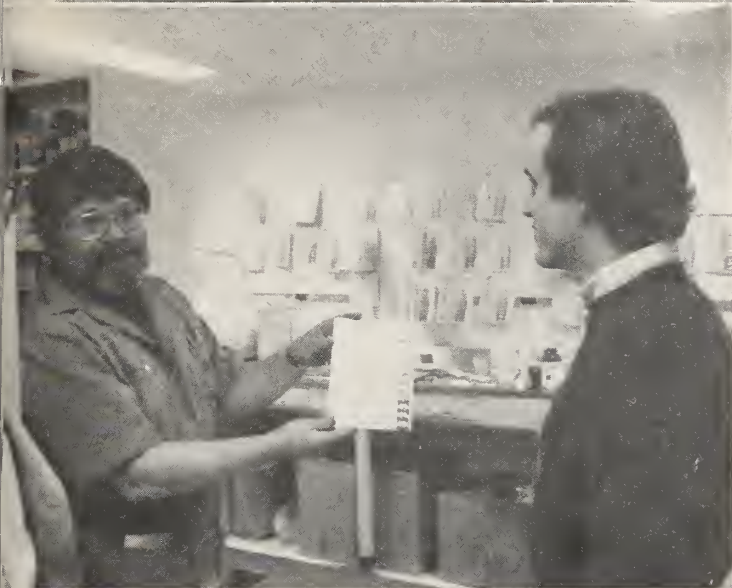


Looking into the infirmary's primary treatment section, G. S. Williams, R. FitzGerald, John Buglewicz and Sandy Went discuss the needs of the infirmary to handle the penitentiary case load.





The infirmary's X-Ray unit which made national news in connection with the inmate X-Ray technician, James Corbett. The unit, itself, is something of an antique; however, staff members say pictures are better detailed from this unit than from some newer equipment, because of the necessary hand-developing of the film. (Top left)

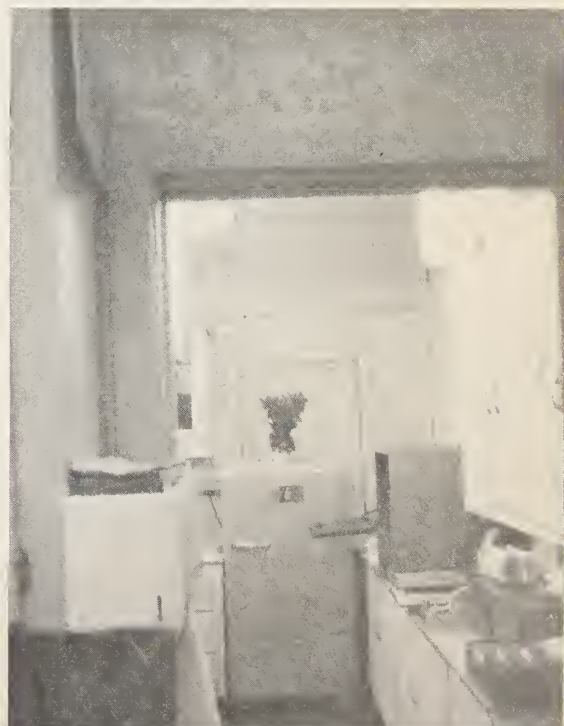


Robert Moore, Prison Medical Director, shows Dr. Buglewicz and Bob FitzGerald the Prison Pharmacy, holding a sample card of prescription capsules which have been packaged, per prison specifications, thereby cutting down on loss through aging of the drugs in bulk storage. (Middle left)



The infirmary laboratory and library. Bob Moore showed the group books which have been left to the prison by inmates. (Bottom left)

The infirmary laboratory handles less than a majority of the required analyses, since most specimen work is sent to the Colorado State Hospital laboratory in Pueblo. The hospital laboratory is able to provide the infirmary with 24-hour service on most lab requests, better than a commercial laboratory could provide the prison. (Below)



# Childbirth and the law

Barbara F. Katz, LLD, Boston, Massachusetts

The legal parameters of the childbirth area are multi-faceted and difficult to define with particularity. Therefore, it is not possible in this short article to analyze in depth all relevant issues. Instead, its purpose is to provide an overview of the critical legal aspects of childbirth in general, and more specifically of homebirths.<sup>1</sup>

## *Practice of Medicine*

Most developments in the law related to childbirth have concerned the practice of midwifery. There has been important activity in both the courts and the state legislatures.

In this area, the courts usually must grapple with the question of whether the practice of midwifery, which involves assistance at a birth, falls within the practice of medicine. The leading case on this subject is a 1907 Massachusetts one.<sup>2</sup> In that case, a woman by the name of *Porn* stated that she had delivered "many women in childbirth for compensation". She was a trained and experienced nurse who had graduated from the Chicago Midwife Institute.

The only question which Massachusetts' highest court, the Supreme Judicial Court, had to decide was whether these actions were within the practice of medicine. In considering this issue, the court stated that "although childbirth is not a disease, but a normal function of women", the practice of medicine is not narrowly confined to the treatment of diseases, and the field of obstetrics is generally accepted as an "important branch of the science of medicine". Accordingly a jury could find that she was engaged in the practice of medicine. The court emphasized that it was bound to find this way

because of the definitions contained in the state's medical practice statute, and that it could have found differently if the state legislature had passed a statute which distinguished the practice of midwifery from that of medicine. Thus, none of those practices were beyond the legislature's power to include within a statutory definition of midwifery.

The next important case in the area is from Texas. In this one, the defendant was charged with the unlawful treatment of a pregnant woman.<sup>3</sup> The issue before the Texas Court of Criminal Appeals was whether to reverse her misdemeanor conviction for the unlawful practice of medicine. The court mentioned the *Porn* case discussed earlier as the only other case dealing with this problem. However, this court held that "the Legislature of Texas had not defined the practice of medicine so as to include the act of assisting women in parturition or childbirth. . .," and accordingly reversed her conviction.

An important recent case involving this issue was decided in California in 1976.<sup>4</sup> The case involved the arrest of several people who were affiliated with the Santa Cruz Birth Center, which provided midwives to assist at homebirths. The court described childbirth as a "physical condition" falling within the medical practice statute, and found that the legislature had an "interest in regulating the qualifications of those who hold themselves out as childbirth attendants . . . for many women must necessarily rely on those with qualifications which they cannot personally verify". The court reasoned that the legislature can legitimately determine that, in order to protect the public's health as regards childbirth, it could mandate that those individuals who present themselves to the public as experts in this area be required

Barbara Katz is Deputy General Counsel of the Department of Public Health for Massachusetts. At the time of writing of the article she was in the Office of the Assistant Chancellor for Legal Affairs and Risk Management at the then University of Colorado Medical Center. Previously she was Director of the Division of Professional and Patient Relations for the Colorado Medical Society.



to meet specific standards and be licensed accordingly. Following this legislative pronouncement in the form of a statute, the actions of any person which falls outside its parameters makes him guilty of the crime of practicing without a license.<sup>5</sup>

Thus, it is evident from the above discussion that it is the prerogative of the state legislatures, in their individual wisdom, to define the boundaries of the practice of medicine. It would therefore be appropriate at this point to discuss the activities of state legislatures in this area.

Statutes in about forty states specifically concern midwifery. The traditional midwife statute was similar to the Minnesota one:

A person desiring to practice midwifery in the state, if not already licensed to do so, should apply to the State Board of Medical Examiners for a license. The license should be granted upon the production of a diploma from a school of midwifery recognized by the Board, or after examination upon the consent of seven members thereof.<sup>6</sup>

However, a number of these laws have recently been significantly revised. Approximately ten states follow the modern trend, which is exemplified by the current Ohio statute. That act requires that an individual have a diploma from a college for nurse-midwives, pass an examination, be of good moral character, and hold a degree in nursing. Midwives licensed under this statute must be under the direct supervision of a physician in their work, which cannot involve complicated births, the use of any instruments, or the treatment of any abnormal condition, except in an emergency.<sup>7</sup> The American College of Obstetrics and Gynecology, as well as the American College of Nurse-Midwives, have taken the position that nurse-midwives should be involved only in births which take place in a hospital, and that generally homebirths should be discouraged. These statutes are supportive of this position. Thus, the statutory trend is in the direction of making it against the law for a licensed nurse-midwife to assist a homebirth, unless of course accompanied by a physician.

It is important to specifically consider Colorado law on this point. Under the Colorado Medical Practice Act, 1973 C.R.S. 12-36-106(1)(f), the practice of medicine is defined so as to *include* the practice of midwifery. Thus, it seems that, under Colorado law, assistance of a woman during childbirth is the practice of medicine, and therefore may only be performed by a licensed physician, *unless* there is an exemption. Two such exemptions are provided

by Colorado statutes. The first one deals specifically with nurse-midwives. House Bill No. 1526, passed by the Colorado Legislature in 1977, amends the previously discussed section of the Medical Practice Act and exempts services provided by nurse-midwives. Furthermore, the act amends 1973 C.R.S. 12-36-106(3), which in general lists exceptions to the definition of medical practice, and provides that the rendering of services by a nurse-midwife certified by the American College of Nurse-Midwives, whose services are performed pursuant to the responsible *direction, supervision, and protocols* of an identified and personally responsible physician does not require a medical license. Thus, it would seem that nurse-midwives who meet these requirements may assist at childbirth.

Beyond that, 1973 C.R.S. 12-36-106(3) also provides a general exemption whereby an unlicensed individual may provide medical services if that individual renders services under the personal and responsible direction and supervision of a licensed physician. Thus, it seems that in Colorado, any person, including the father, may legally participate in a birth, as long as he does so under the personal direction and supervision of a licensed physician, who will be legally liable and accountable for the rendering of the services by the unlicensed individual.<sup>8</sup> Obviously, the quantity and amount of supervision and direction that is required will depend upon the competence of the individual who is being so supervised and directed.

#### *Potential Liability Under the Civil and Criminal Law*

In general, the legal system only concerns itself with the outcome of actions. Accordingly, unless a particular situation involves the unlawful practice of medicine or midwifery, as discussed earlier, there would probably not be any legal action which would or even could be taken against the parents, a friend of the couple, a midwife, or a physician for participation in a homebirth unless the mother or child dies or is permanently disabled during the birth. Beyond that, the mother will probably not be able to sue any other person for injury to herself or death if there has been no negligence, since, as concerns herself, she will likely be considered to have knowledgeably assumed the risk of homebirth. Therefore, only in the situation in which the

child either dies or is seriously injured because of the fact that the birth was planned to and occurred at home could there be potential liability. This article will accordingly deal only with such situations, with the additional requirement that it can be shown that, had the delivery taken place in a hospital, the infant would have lived. In the absence of this last fact, it is still unlikely that a civil or criminal suit based on the child's death would be successful.

### *Liability of the Parents*

Applicable cases indicate that, before the infant is born, neither parent will be held legally responsible for not obtaining medical assistance. For example, in 1954 the Wyoming Supreme Court reversed the manslaughter conviction of a woman whose child died shortly following his delivery.<sup>9</sup> In its decision, the court observed that it could not find any legal basis for placing on a pregnant woman the obligation to seek medical care for her fetus. It therefore affirmed the proposition that the parents' duty in this area only begins following the infant's birth.

However, the law is clear in imposing a duty on the parents following birth to provide an infant with necessary medical assistance, so that their failure in this regard would be child neglect to the extent that it could, in the extreme, be homicide.<sup>10</sup> Every state has a child abuse law which, in forbidding parents from abusing their offspring, also places on them a requirement to obtain necessary medical care for their children. Thus, parents may generally decide to have a homebirth without worry about potential legal liability. However, if they knew or reasonably should have known the likelihood of the development of complications of the type which require hospital care in order to prevent the infant's death or serious permanent injury, and this risk develops into a reality because of the homebirth, it is possible that criminal charges could be brought against the parents. In both instances the complaint could be for child abuse, and, if the infant dies, may be for manslaughter, depending on the actual cause of death and its reasonable predictability.<sup>11</sup> This potential liability is an attempt by the law to discourage people from having unassisted homebirths, and to encourage them to obtain an appropriate attendant for any homebirth, while

seeking hospital care when reasonably necessary to protect the health and life of the infant.

Without prior indications of reasonably-anticipated problems, the liability of the mother for neglecting to care for the infant is unlikely to be significant immediately following the birth. However, the father could be held accountable for any failure to summon or seek needed medical care for the infant. For example, the jury instructions in a 1905 case were to the effect that a father could be found guilty of the crime of manslaughter for the death of his infant caused by his dereliction of his obligation "when the woman was in the pains and perils of childbirth to summon aid."<sup>12</sup>

Some physicians are concerned about possible increased malpractice liability for participating in a homebirth. This is probably due to a misunderstanding of the law in the medical malpractice area in general, as well as the climate of fear that exists in many places.<sup>13</sup> The view has been voiced that, in some localities, the applicable standard for judging medical care is to have all deliveries in the hospital, so that it is negligence *per se* for a physician to attend a birth at home. This is not true. If the woman decides to have a homebirth, after being fully informed of all possible risks and dangers, and if all reasonable medical actions have been taken involving screening the woman for a potential high-risk pregnancy and emergency backup facilities, a malpractice suit against the involved physician would very likely be unsuccessful. In this area, the legal obligation of the woman's physician to the fetus is to provide it with adequate medical care both before and during the birth. In general, the duty does not set up an insurmountable obstacle to a physician's participation in a homebirth. However, it does require that the physician undertake standard screening procedures for determining high-risk pregnancies, and in some manner to encourage such individuals to have the birth in a hospital. This defensive approach should be rejected on policy grounds as well, in that it would not deter those persons who are committed to having their children at home from doing so, but only make it impossible for them to obtain medical assistance if they desired it.

However, it is also true that a physician is under no obligation to include homebirths as a part of his practice. Thus, a physician would not be liable for abandonment of his patient in a



situation in which he had indicated that he would not assist with a homebirth and later declines to give aid when his patient contacts him during delivery. For example, in one case the physician told his patient that the only appropriate setting for a birth was in the hospital "where proper facilities were available," and refused to agree to assist with her planned birth at home. The woman thereupon hired a midwife. When complications occurred in the course of the birth, she called this physician, as well as two others. All declined to respond, and the infant died. The court would not find the defendant physician negligent for his failure to respond to her request for assistance.<sup>14</sup>

### *Childbirth in the Hospital Setting*

The alternative for couples who desire a "homebirth-like atmosphere" for the delivery of their child, but want to have the birth take place in a hospital, is to take advantage of recent changes and developments in traditional methods of hospital-based delivery. "Husband-coached" childbirth, usually the Lamaze or psychoprophylactic methods, in which the father is with the mother during the course of labor and delivery, is generally allowed in a majority of maternity wards. However, it should be noted that lawsuits brought to force unwilling hospitals to adopt this position have all met failure, regardless of whether the institution involved was private or public, or whether the plaintiff was a pregnant woman or her obstetrician.<sup>15</sup>

The conclusion from the cases in this area is that rules promulgated by hospital administrators will probably be upheld by courts as long as the hospital can show that the rule in question has a reasonable connection to improved patient care. Beyond that, these rules will also be enforced by courts against individual physicians, patients, or both, assuming that the institution observes minimal due process standards, as those are usually contained in the hospital's own bylaws.<sup>16</sup> Thus, lawsuits opposing hospital regulations which prohibit certain procedures, such as Lamaze or Laboyer, will most likely fail.

As the state of the law currently exists, when using a hospital's facilities, both the parents and their physician must abide by the institution's rules as concerns deliveries, including such items as the presence of the father and/or others in the delivery room, method of delivery, etc. However, the woman does have, as a corollary to the right to give informed consent, the right to refuse to consent to any particular medical procedure or drug, such as anesthesia or episiotomy.<sup>17</sup> Thus, patient control may be exercised in a reactive way. Although the patient cannot demand that things happen in a certain way, she can refuse to proceed with those things offered to which she objects. Assuming the availability of an appropriate hospital setting and a cooperative physician, this situation may be entirely satisfactory. The alternative to hospital policies viewed as too restrictive is, of course, birth outside the hospital, so that hospitals may be well advised to be receptive to patient concerns in this area if encouragement of hospital-based deliveries is desired.

### *Conclusion*

Thus, the childbirth area defines its legal boundaries through the action of state legislatures and individual hospitals, if one is involved. There is no absolute ban on the undertaking of homebirths, but certain restrictions may exist depending to an extent on the definition of medicine in a particular state and the type of birth attendant involved. Beyond that, there may also be the possibility for criminal or civil liability on the part of the involved parties, although the circumstances under which this would be a realistic possibility are somewhat limited. Finally, while hospitals may want to respond to the desire of some patients to have hospital-based births be more home-like, the legal system recognizes this as essentially a policy decision to be made by the health-care institution, and will not at the present time interfere or attempt to enforce a different childbirth philosophy. ●

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- <sup>2</sup> *Commonwealth v. Porn*, 196 Mass. 326 (1907).
- <sup>3</sup> *Banti v. State*, 289 S.W.2d 244 (Tex. Ct. Crim. App. 1956).
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- <sup>5</sup> See Attorney Gen. Op. regarding midwifery, Maine, January 27, 1977, (midwifery for compensation violates nurse practice act) and Op. No. 7468 on midwifery, Oregon Atty. Gen., June 17, 1977, (midwife can assist at childbirth but cannot administer drugs or perform episiotomy).
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- <sup>9</sup> *State v. Osmus*, 73 Wyo. 183, 276 P.2d 469 (1954).
- <sup>10</sup> J. Robertson, "Involuntary Euthanasia of Defective Newborns: A Legal Analysis", 27 *Stanford L. Rev.* 213, 218-30.
- <sup>11</sup> See *State v. Shepard*, 255 Iowa 121S (1973).
- <sup>12</sup> *Commonwealth v. Signerski*, 14 Pa. Dist. 361 (1905).
- <sup>13</sup> Annas, G.J., Katz, B.F. and Trakimas, R.B., "Medical Malpractice Litigation under National Health Insurance: Essential or Expendable", 1975 *Duke L.J.* 1335.
- <sup>14</sup> *Vindrine v. Mayes*, 127 So. 2d 809 (Ct. App. La. 1961).
- <sup>15</sup> *St. Vincent's Hospital v. Hulit*, 520 P.2d 99 (Mont. 1974); *Fitzgerald v. Porter Mem. Hosp.*, 523 F.2d 716 (7th Cir. 1975); *Justus v. Atchison, Powell v. Atchison*, 126 Cal. Rptr. 150 (Ct. App. 2d Dist. 1975).
- <sup>16</sup> See *Fahey v. Holy Family Hosp.*, 336 N.E.2d 309 (Ill. 1975); *Khan v. Suburban Comm. Hosp.*, 340 N.E.2d 39S (Ohio 1976); *Sosa v. Board of Managers of Val Verde Mem. Hosp.*, 437 F.2d 173 (5th Cir. 1971).
- <sup>17</sup> Annas, G.J., *The Rights of Hospital Patients* 1975.

## DISCUSSION

Barbara Katz's study of *Childbirth and the Law* is an excellent precis, worthy as a starting point for anyone interested in homebirth. One feels uneasy, however, with her conclusion that possibilities for civil or criminal liability among involved parties are "somewhat limited."

Health records show that, in Colorado, 37.2 of every 1,000 infants born out-of-hospital dies within one year. Less than half that number, 15.8 of every 1,000 in-hospital born, meet death within the first year.<sup>1</sup> Such statistics have convinced every malpractice insurer I can find that physicians scheduling home deliveries should not be insured.

I wish Ms. Katz had discussed the proposition that physicians in obstetrics owe a duty to the unborn child as well as to the parents. Analogous is the "wrongful life" case in which an action in damages is brought by the child alleged to have been born as a result of the physician's negligence.<sup>2</sup> To us more timorous souls, this implies that provision of substandard medical care, notwithstanding informed parental consent, is asking for trouble.

Supervision of birth attendants such as midwives is an area for great caution. The amount of supervision required depends not only upon the attendant's competence, but also upon the complexity of the task. No one can identify with certainty, except as hindsight, the low risk mother. With the possibility of complications always present, supervision must be stringent.

I am also left yearning for a philosophical discussion of the profound difficulty that homebirth poses for doctors who are forced to measure the value of homebirth for parents against the rights of the child. Childbirth is a familial decision in the sense that the parents are entitled to critical scrutiny and moral judgments. But how far should medicine go in recognizing contemporary lifestyles?<sup>3</sup>

Law and medicine face hard choices in reconciling the interests of parents with those of children. Such decisions cannot be scoffed at as low-risk. Neither can they be successful without accommodating the legitimate interests of all concerned.

Brian K. Stutheit, JD  
Denver, Colorado

Mr. Stutheit is Director of Division of Professional and Patient Relations for the Colorado Medical Society.

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- <sup>2</sup> *Becker v. Schwartz*, 400 N.Y.S. 2d 119 (App. Div. 1977).
- <sup>3</sup> For a good discussion, see A. Buchanan, "Medical Paternalism or Legal Imperialism," 5 (2) *American Journal of Law and Medicine*, 97 (Summer 1979).





Bob Hahn, DMS, David Johansen, UCHSC, and KMGH-TV Audio Engineer Neal Allen, during the "Medicaline" program on Channel 7. Bob, David and Neal take questions phoned in by viewers for the participating doctors to answer during the program.

Roger Hamstra, "Medicaline" host and producer, as he prepares for the Sunday evening program, live on Channel 7 KMGH-TV. Guests are l. to r.: Karl T. Chambers, M.D., member of the Denver Medical Society and specialist on Arthritis; Roger Hamstra, M.D., Associate Professor of Medicine, Department of Medicine, Univ. of Colorado School of Medicine, and; Jerome D. Wiedell, M.D., University of Colorado Health Sciences Center.



The executive staffs of the Colorado Medical Society and the Colorado Foundation for Medical Care met in an all-day planning session at the Denver Holiday Inn on Friday, January 25.

Members of the Metropolitan Council of Auxiliary Presidents of the Colorado Medical Society met at Denver's Wellshire Inn on January 31st. M. Roy Schwarz, M.D., Dean of the University of Colorado School of Medicine, addressed the all day session.





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# council on legislation

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At meetings during the month of January, the Council heard representatives from the Colorado Hospital Association, Blue Cross/Blue Shield, Health Insurance Association and Kaiser Foundation. Principal topics of discussion were: consideration of the Board of Medical Examiners Proposed Rules and Regulations for Non-Physician Health Care Providers, the position that the Council should take on the continuance of the Colorado Hospital Commission, proposed legislation concerning Certificate of Need, and physicians' salaries at state institutions. The following actions were taken:

- The Council opposes any provision of state law which would appear to favor HMO's unfairly over the fee-for-service practitioner and in particular, compliance with the new federal rules and regulations on Certificate of Need.
- Resolved that the Council on Legislation does not feel that government regulations are the solution to health care cost containment and therefore, does not support the Colorado Hospital Commission.
- Referred the child abuse legislation to the staff of the Council on Public Health for review and recommendations.

The Council will be meeting on a weekly basis throughout the 1980 legislative session. All CMS members are encouraged to utilize the Legislative Hotline for the current status of bills (832-9527). For additional information on bills and legislative issues, please contact the Government Affairs Division (861-1221, Ext. 266 or WATS 1-800-332-4150).

## Postoffice Probes Directory

U.S. Postoffice authorities are investigating a Miami, Florida firm known as the U.S. Directory Service which asks physicians to pay \$20 to "participate" in a medical directory listing. It is important that it be recognized this firm has nothing to do with the American Medical Directory, published by the American Medical Association, which lists all U.S. physicians. Such similar solicitations were made to physicians in 1972 and 1978.

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## new members

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**Denver Medical Society:** Francine G. Andrews, Bruce B. Baker, Alan Dubelman, Joseph Z. Forstot, Richard M. Jacoby, Kenneth B. Kauvar, Lennard J. Kessler, Allan R. Liebgott, Meng Lai Lim, Daniel L. Marier, Thomas C. Nilsson, William F. Orr, Jr., Rik Santaguida, James E. Shira, Warren H. Toews, Drew E. Tuckman, Charles Tuft.

**Larimer County Medical Society:** Bert Eugene Bergland, Christian E. Hageseth, Thomas P. Monath, Roger M. Sobel, Harry D. Starnes, Robert J. Tello, Mark Edward White.

**Washington-Yuma Counties Medical Society:** Bruce C. McComas.

**Mount Sopris County Medical Society:** Ben R. Keller, Jr.

**Eastern Colorado Medical Society:** Michael S. Victoroff.

**Northeastern Colorado Medical Society:** Craig H. Van Schooneveld.

**Weld County Medical Society:** William J. Milano.

**Arapahoe County Medical Society:** James T. Harwood, Jr., Victor R. Lee, James K. Quimby.

**Clear Creek Valley Medical Society:** Nancy B. McElair, Barber J. Parks, Douglas M. Shasby, Eric H. Smith.

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## Spend a Day at the Capitol

This is your opportunity to learn the legislative process and meet with your legislators at their work stations. The Government Affairs Division invites all component societies to come to Denver, meet with your individual legislators, tour the Capitol, and attend committee hearings. Get your group together, decide on a date and then call the Division Offices (861-1221, Ext. 266 or WATS 1-800-332-4150) - staff will complete the arrangements for an interesting and educational day.



The first week of January found Dr. Mason Howard and Dr. Joel Karlin plus Brian Stutheit and me at an AMA conference at the Biltmore in Phoenix learning all there is to know about legislation and solutions in other states and about lobbying techniques. Other than a six-hour delay in the Denver airport, the trip was super; and we came home with many new ideas and contacts.

Representative Steve Durham (R), Colorado Springs, took the place of Senator Fred Anderson (R), Loveland, on a panel discussing federal vs. state control of health care costs. Senator Anderson has helped AMA at many meetings, but this was a first for Representative Durham. He was superb!

He followed Congressman Waxman of California, the House sponsor of the Kennedy health insurance bill and a believer in strict government control of health care. Representative Durham is an avid believer in state and local rights and in involuntary cost containment. He was interrupted by applause several times and will be receiving many AMA invitations in the future.

Dr. Bob Brittain was his usual excellent self in a speech on the truth behind malpractice suits. As I waited in front of the hotel for a friend to take me to the airport, I overheard some wonderful comments about his just-finished speech. As one surgeon said, "I wouldn't take that from an outsider, but that darned guy knows he's right — and so do we."

Another panel spoke on residency requirements and medical school problems and featured the California state health planner (who made my back stiffen throughout his speech) vs. the Dean of the University of Southern California Medical School. Still another panel considered the problem of delivering health care to underserved areas via allied health personnel, and of course the nurse practitioner and physician assistant problems rose quickly to the surface.

As with any conference, the greatest value is the individual discussions with the right person from the right state or office. There was lots of opportunity to corner AMA staff, National Conference of State Legislatures staff, lobbyists and government affairs specialists from other states. And I did it all — and never touched my tennis racquet!

Thank you for another fun learning experience.

*David Longest*

## JOINT MEDICAL/LEGAL SYMPOSIUM

Physicians and lawyers met at the University of Denver Law School Auditorium Tuesday, December 11, 1979, in a joint meeting of the Denver Medical Society and the Denver Bar Association. Under discussion was the revised Guide for Interprofessional Relations, printed and distributed recently by the Colorado Medical Society and the Colorado Bar Association.

District Judge Charles A. Friedman was the moderator of a panel. The physicians on the panel were: Wallace H. Livingston, MD, Dennis M. Mahoney, MD, JD, J. Phillip Nelson, MD, Peter Rosen, MD.

The panel also included Denver District Judge Joseph Quinn and three lawyers: Bennet S. Aisenberg, JD, George G. Johnson, JD, Gerald P. McDermott, JD.

Following opening remarks, a hypothetical automobile accident case was presented by Mr. Johnson. The panel and audience discussed the various medical and legal problems posed by the case for nearly two hours. Included were such aspects as:

- The ethical question posed by the defense attorney calling the plaintiff's doctor for information without getting the plaintiff's consent. (Answer: the general consensus was that it was improper.)
- The physician's need to protect the doctor-patient relationship; when does a patient waive the doctor-patient privilege? (Answer: It depends upon the circumstances, but it must be remembered that the patient maintains the right to waive or not waive the privilege.)
- What information should a physician give a defense lawyer when he requests a written report on the history of the plaintiff, diagnosis and prognosis? (Answer: Provided proper authorization has been received from the plaintiff, the doctor should answer the specific questions raised by the lawyer in a factual manner.)
- Is it ethical for a physician to refuse to testify until the plaintiff's (his patient's) medical bill is paid? (Answer: No.)

• Is it ethical for a physician who is asked to testify to request that his testimony fee is paid before he testifies? (Answer: Yes; the amount and time of payment of fee should be discussed before the testimony is given.)

• Can a physician be forced to say anything about the medical aspects of a case to any attorney before formal proceedings are filed in a case? (Answer: No, unless a written patient release of records is provided.)

Those who attended felt the meeting achieved its purpose of being an educational effort, not only in answering specific questions, but in acquainting lawyers with problems physicians face in dealing with the courts and acquainting physicians with problems lawyers face in dealing with doctors.

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## staff profile

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I was born in New Jersey, but my folks had the good sense to move to Miami, Florida when I was 7 years old. I lived there for 15 years, went to school and became a Medical Assistant, got married, and moved to Denver. Looked around a number of years getting closer and closer to the "right job" and found it at the C.M.S. in April, 1979 as Staff Assistant for the Division of Continuing Education.

Husband Chuck, 2-year-old Aubrey and I have a house in Northwest Denver which we are fixing up little by little. Other hobbies are cross-country skiing, performing alchemy with food (e.g., turning a red, juicy steak into a replica of something from Skylab returned to earth), and keeping up on my current cerebral pastime, transuranium element locales in Colorado, which ties in nicely with my husband's summertime passion of mineral collecting and sliding down mountainsides.

I would like to pursue courses in the near future in speedwriting, auto mechanics for simpletons and, of course, cooking.

**IRENE HOBART**



## WESTON ELECTED TO ACADEMY BOARD

William L. Weston, MD, Chairman, Department of Dermatology, University of Colorado Health Sciences Center, has been elected to the Board of Directors of the American Academy of Dermatology.

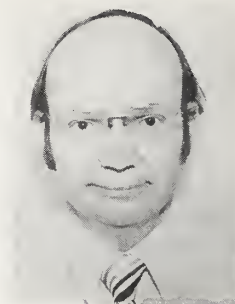
Dr. Weston is founder and Secretary-Treasurer of the Society of Pediatric

Dermatology. He also is on the Board of Directors of the Society of Investigative Dermatology. From 1975 to 1976, he served as President of the Colorado Dermatologic Society.

Dr. Weston is chairman of the 1980 American Federation for Clinical Research, Western Section of Dermatology.

He was graduated from the University of Colorado Medical School where he also completed his dermatology residency. He was a pediatrics resident at Colorado and the University of California School of Medicine in San Francisco.

The American Academy of Dermatology is the professional association for over 95 percent of the physicians specializing in the education, practice and management of diseases of the skin.



## Schoonmaker Named Governor

Fred W. Schoonmaker, MD, Denver has been elected to a three-year term as Colorado-Wyoming governor for the American College of Chest Physicians.

Dr. Schoonmaker is founder of the Rocky Mountain Heart Research Foundation housed in St. Luke's Hospital, a division of Presbyterian/St. Luke's Medical Center.

Dr. Schoonmaker's innovative catheter technic which is used in diagnostic cardiology was reviewed in worldwide seminars last fall. The Cleveland Clinic, where Dr. F. Mason Sones, Jr., first studied coronary arteries with a catheter as suggested originally by Dr. Radnor of Munich Germany, held a symposium to commemorate "A Generation of Coronary Arteriography" in October, at which Dr. Schoonover lectured.

In November, Dr. Schoonover lectured at the National Society for Cardiopulmonary Technology, and earlier he addressed the Sixth Asian Pacific Congress on Diseases of the Chest, held in Bombay, India.



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# condensed minutes

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1. Approved referring the following items to the Organizational Study Committee for study and/or preparation of amendments to the Constitution and By-Laws:
  - A. A recommendation that the immediate past president be a voting member of the Board of Trustees; and
  - B. The possibility of amending the Constitution and By-Laws at either the Interim Session or the Annual Session.
2. Authorized an expenditure of up to \$2,500 to cover per diem and transportation for members of the Physician Health and Rehabilitation Committee traveling around the state during the organizational stages of the impaired physician program.
3. Authorized an expenditure of \$4,653.00 so that the Colorado Medical Society may enter into the AMA/Law Enforcement Assistance Administration Jail Project Grant.
4. Directed that a special report or resolution be prepared by the Board of Trustees, for introduction to the House of Delegates, which presents a brief historical sketch of the matter of non-physician health care providers — a copy of the Proposed Rules and Regulations Pertaining to the Supervision and Direction of Non-Physician Health Care Providers is to be included.
5. Directed the Council on Socio-Economics to research the reasons for the recent demise of the Larimer County HMO in view of its far reaching implications.
6. Approved the Risk Management Committee recommending creation of a category of rate classification under the CMS/Hartford program for family practitioners involved in giving general anesthesia for elective cases.
7. Approved Jan Hildebrand, M.D. completing Dr. Donald Johnston's term on the Board of Trustees as a representative from District IV.
8. Accepted for information the Quarterly Report, July through September 1979, of the Risk Management Committee.
9. Directed the Executive Committee of the Board of Trustees to perform an evaluation of the Executive Vice President on an annual basis, as outlined in the guidelines presented to the Board — the evaluation is to be conducted at the time of budget preparation.
10. Approved the following actions taken by the Executive Committee of the Board of Trustees at its meeting on December 13, 1979:
  - A. Approved an expenditure of \$17,400 to cover the costs involved in relocating CMS staff in the Denver Medical Society Library Building.
  - B. Approved distribution of balance of the interest income from the Colorado Medical Foundation Trust to the following Colorado charitable 501(c)-3 organizations: Hall of Life; Colorado Heart Association; and the Colorado Diabetes Association.

**MEMBERS PRESENT:** Ray Witham, M.D., President

K. Mason Howard, M.D., President-elect

District I - David Bates, M.D.; Merlin Otteman, M.D.

District II - Jerry Appelbaum, M.D.; William Jobe, M.D.; Abraham Kauvar, M.D.; Frederick Lewis, Jr., M.D.; Joseph Poynter, M.D.; Wilfred Stedman, M.D.

District III - J. Richard Brusenhan, M.D.; Amilu Martin, M.D.

District IV - Hanns Schwyzer, M.D.

District V - Robert Linnemeyer, M.D.

**MEMBERS ABSENT:** District II - Philip Norton, M.D.

**EXCUSED**

District IV - Donald Johnston, M.D.

District V - Telford Davis, M.D.

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## letters to the editor

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Holistic Medicine is  
The soft cry of the public  
for the return of the art of medicine -

Not the abolition of the science,  
with its inrush of artistic charlatans

But perspective, with its balance  
between caring and curing

So the human condition may be served  
as it exists.

Loring Brock, MD  
Denver

Enclosed is an up-date of the Colorado Child and Adolescent Psychiatric Society's CME program for the balance of the academic year. I'm sorry you apparently did not receive the correction to our CME related to the March 5th meeting. We did away with the title "My Parent the Shrink" soon after it was first announced, since it came as an affront to the psychiatrist involved with the program. Instead, the title was changed (in October) to "Developmental Issues for the Children of Psychiatrists," as noted herein. If you can print something in the next *Colorado Medicine* that would acknowledge our oversight in informing you of this change of the correct title, I'd appreciate it. Also, other changes to note re: our CME: a room change from 2K08 to Room 2H17 in CPH, above the Rene Spitz Library) and our address change for information: now same as Colorado Psychiatric Society: CCAPS, 1555 East Lake Place, Littleton, Colorado 80121, Phone 795-8404. Thank you.

James W. Lauer, MD  
Denver

Colorado Medical Society members will find a number of new features at the scientific program of the CMS Interim Session, March 1, 1980.

**All-day workshops** (each offering 6 hours of Category 1 credit) will be held on the following topics:

- Care of the Cancer Patient by the Primary Care Physician
- The Physician's Role in the Wellness Movement
- Community Practice and the Treatment of Coronary Disease
- Practice and Personal Financial Management

A few of the speakers are: Gerald P. Bodey, MD, of M.D. Anderson Hospital, Houston, Texas, who will present the *Lanning E. Likes* presentation, "Infectious Complications of Malignant Disease and Their Treatment" during the Cancer workshop; H.L. Brummel, MD, Associate Professor of Medicine and Physical Medicine and Rehabilitation, Webb-Waring Lung Institute, Denver, will present "Exercise Prescription" and "Cardiac Rehabilitation" for the combined attendees of the Wellness and Coronary Care programs; Mr. Art Ammann, Research Director for Boettcher and Company, will present "Colorado Economic Forecast" for the Financial Management Workshop.

**The Physicians Learning Resources Center** will include presentations of PLATO (Control Data Corporation), MEDLINE (Denver Medical Society Library), Apple II (Milliken Corporation), and displays by the University of Colorado Health Sciences Center, Office of Educational Services. Other displays are still under consideration and discussion. The Learning Resources Center will be open from 8:00 a.m. to 6:00 p.m. to accommodate those people attending the scientific workshops. Hands-on experience will be available on most of the equipment displayed to give attendees a real feel for their operation.

All interested physicians are invited to attend the program.

A Practice Management course will be held at the Winter Clinics, March 1, 1980. This is the second time such a service has been offered. The lineup is impressive:

- Mr. Art Ammann, Boettcher Company, *Colorado Economic Forecast*
- Assistant Dean Christopher Munch, University of Denver School of Law, *Professional Corporations and Partnerships*
- David Burlingame, JD, *Estate Planning*
- Sterling Drumwright, Director, Colorado Health Facilities Review Council, *Certificate of Need and Your Practice*
- Marvin Hanson, Director, Central-Northeast Health Systems Agency, *Certificate of Need and Your Practice*



# CONTINUING MEDICAL EDUCATION CALENDAR

PUBLISHED JOINTLY BY THE COLORADO FOUNDATION FOR MEDICAL CARE, COLORADO MEDICAL SOCIETY AND THE COLORADO ACADEMY OF FAMILY PHYSICIANS • 1601 EAST NINETEENTH AVENUE, DENVER, COLORADO 80218

## MARCH 1980

### 1st-8th

**CANADIAN AMERICAN MEDICAL DENTAL ASSOCIATION MEDICAL PROGRAM.** Snowmass, CO. Contact: Robert Allot, M.D., 550 Osborne Blvd., Sault Ste. Marie, Minnesota 49783.

### 4th-9th

**NEW MEXICO ACADEMY OF FAMILY PHYSICIANS.** Ramada Inn, Durango, CO. Contact: David Holten, M.D., Albuquerque Academy of Family Physicians, #105, 2650 Yale Blvd. SE, Albuquerque, New Mexico 87106.

### 7th-8th

**A MATTER OF LANGUAGE - VII ANNUAL READING/LEARNING DISABILITIES WORKSHOP.** Colorado Women's College, Denver. Contact: Health Education Department, The Children's Hospital, 1056 E. 19th Ave., Denver, CO 80218. 861-6947. (AMA Category 1 hours available).

### 9th

**SYMPOSIUM ON ALCOHOLISM.** Writer's Manor, Denver. Contact: National Council on Alcoholism, 2525 W. Alameda Ave., No. 214, Denver, CO 80219. (8 hours of AMA Category 1 credit).

### 9th-13th

**COLORADO DIABETES INSTITUTE.** Aspen Institute, Aspen, CO. Program Director: Robert N. Alsever, M.D. Contact: American Diabetes Association Colorado Affiliate Inc., 1045 Acoma, Denver, CO 80204. 573-8833.

### 10th-15th

**26TH ANNUAL FAMILY PRACTICE REVIEW.** Denver. Contact: Office of Postgraduate Education, University of Colorado Health Sciences Center, 4200 E. 9th Ave., Denver, CO 80262. 394-5241.

### 13th-14th

**ISSUES FOR THE 80'S: COLORADO MENTAL HEALTH CONFERENCE ON CHILDREN AND ADOLESCENTS.** Landmark Inn, Denver. Contact: Health Education Department, The Children's Hospital, 1056 E. 19th Ave., Denver, CO 80218. 861-6947.

### 15th-22nd

**RECOGNITION AND MANAGEMENT OF THE STROKE PATIENT.** The Mark, Vail, CO. Contact: Faith Carlisis, College of Medicine, Health Sciences Center, Tuscon, Arizona 85724.

### 15th-22nd

**MERCY UNITY HOSPITAL ANNUAL WINTER SEMINAR.** Keystone, CO. Contact: Minnesota Academy of Family Physicians, 8455 Flying Cloud Drive, Eden Prairie, MN 55344. 612-944-3585.

### 17th-19th

**THE J. CUTHBERT OWENS SYMPOSIUM ON THE EARLY CARE OF THE INJURED PATIENT.** Brown Palace Hotel, Denver. Contact: John A. Boswick, Jr., M.D., Course Director, 4200 E. 9th Ave., Box C-309, Denver, CO 80262. 394-8718 (22 hours of AMA Category 1 credit).

### 20th-21st

**4TH ANNUAL PEDIATRIC CARDIAC CONFERENCE.** Children's Hospital, Denver. Contact: Health Education Department, The Children's Hospital, 1056 E. 19th Ave., Denver, CO 80218. 861-6947. (9 hours of AMA Category 1 credit).

### 31st-April 4

**HIGH RISK INFANT CARE.** Denver. Contact: Office of Postgraduate Education, University of Colorado Health Sciences Center, 4200 E. 9th Ave., Denver, CO 80262. 394-5241.

## APRIL 1980

### 2nd

**NEUROPSYCHIATRIC GRAND ROUNDS.** Colorado State Hospital, Pueblo. Contact: Jay Scully, M.D., 1600 W. 24th St., Pueblo, CO 81003. 543-1170.

### 9th-11th

**3RD ANNUAL CONFERENCE ON NEONATAL TRANS-PORT.** Sheraton-Denver Inn. Contact: Health Education Department, The Children's Hospital, 1056 E. 19th Ave., Denver, CO 80218. 861-6947. (20 hours of AMA Category 1 credit).

### 11th-12th

**RECENT ADVANCES IN MANAGEMENT AND PREVENTION OF CARDIOVASCULAR DISEASE.** Four Seasons, Colorado Springs, Contact: Curtis C. Steine, M.D., 388-6288, ext. 2341. (10 prescribed hours of AAFP credit).

## MAY 1980

### 5th-10th

**DENVER POSTGRADUATE INSTITUTE IN EMERGENCY MEDICINE.** Denver General Hospital. Contact: Peter D. Bryson, M.D., Denver General Hospital, W. 8th Ave. and Cherokee, Denver, CO 80204. 893-7034.

### 7th

**NEUROPSYCHIATRIC GRAND ROUNDS.** Colorado State Hospital, Pueblo. Contact: Jay Scully, M.D., 1600 W. 24th St., Pueblo, CO 81003. 543-1170.

**7th**

**THE SOCIALLY ASSAULTED CHILD.** Denver. Contact: Colorado Child and Adolescent Society, Colorado Medical Society, 1601 E. 19th Ave., Denver, CO 80218. 861-1221, ext. 241.

**8th-11th**

**JOINT MEETING OF COLORADO CHAPTER OF AMERICAN COLLEGE OF SURGEONS AND COLORADO DIVISION OF AMERICAN CANCER SOCIETY.** The Broadmoor, Colorado Springs. Contact: Colorado Medical Society, Attn.: Vi Brown, (303) 861-1221, ext. 241.

**15th-18th**

**10TH ANNUAL CHILD ABUSE AND NEGLECT SYMPOSIUM.** Keystone, CO. Contact: Office of Postgraduate Education, University of Colorado Health Sciences Center, 4200 E. 9th Ave., Denver, CO 80262. 394-5241.

**16th**

**INTERNAL MEDICINE POSTGRADUATE DAY: CARDIOLOGY.** Denver. Contact: University of Colorado Health Sciences Center, 4200 E. 9th Ave., Denver, CO 80262. 394-5241.

**JUNE 1980****22nd-26th**

**THIRD INTERNATIONAL SYMPOSIUM - CANCER THERAPY BY HYPERTHERMIA, DRUGS, AND RADIATION.** Colorado State University, Fort Collins, CO. Contact: D. W. C. Dewey, Dept. Radiation Biology, Colorado State University, Fort Collins, CO 80523.

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## 1980 DATES TO DO SOMETHING ABOUT

<b>April 4</b>	Elector must be a resident of precinct 32 days to be eligible to vote in caucus. <b>THIS IS THE DEADLINE!</b>
<b>April 25</b>	Last day to post precinct caucus signs.
<b>May 5</b>	Precinct Caucus Night.
<b>May 15</b>	Last day for precinct committee people to submit list of election judges for county chairman.
<b>May 17</b>	Denver County Republican Assembly/Convention
<b>May 30-31</b>	Denver County Democratic Assembly/Convention
<b>June 7</b>	Republican State Convention - McNichols Arena
<b>June 11</b>	First day to apply for absentee ballot for Primary Election
<b>June 13-14</b>	Democratic State Convention - Boulder
<b>July 8</b>	Branch registration opens for Primary Election
<b>August 6</b>	First day to apply for absentee ballot for General Election
<b>August 8</b>	Last day to register for Primary Election. Last day to change party affiliation to vote in Primary Election.
<b>September 5</b>	Last day to apply for absentee ballot for Primary Election
<b>September 9</b>	Primary Election Day
<b>September 10</b>	First day to register for General Election
<b>October 3</b>	Last day to register for General Election
<b>November 4</b>	General Election Day



## MEDICAL OPPORTUNITIES

**NEEDED:** General Internist or Family Practitioner, Board eligible or Board certified to join three MD's and one PA in thriving primary care clinic. Clinic in outlying town, 17 miles from a hospital with all major subspecialties and services available. Occupational medicine and pediatrics practiced. Write: Palisade Family Practice Clinic, P.O. Box 920, Palisade, Colorado 81516, or call: (303) 464-5183. 579-9-TFB

**ROCK SPRINGS, WYOMING - EMERGENCY MEDICINE PRACTICE AVAILABLE IN STABLE FIVE PHYSICIAN GROUP.** Excellent fee for service contract, seeing variety of trauma and medical patients. New hospital with specialty back up. Ideal location with proximity to Jackson, Steamboat Springs, and Salt Lake City. Send CV to Box 779-10-TFB, c/o Rocky Mountain Medical Journal, 1601 East 19th Avenue, Denver, Colorado 80218. 779-10-TFB

**PRACTICE OPPORTUNITIES IN THE NORTHWEST.** Our firm manages a number of hospitals in communities in Northwest. For information regarding practice opportunities send your CV to Dale Hanson, A.E. Brim and Associates, Ltd., 177 N.E. 102nd Avenue, Portland, Oregon 97220, or call: (503) 256-2070. 979-1-6B

**PHYSICIAN WANTED FOR full or part-time work.** Aspen-Snowmass Area. Fee for service with generous remuneration. Plenty of time to ski. This is a unique opportunity, and we need doctors now. Call: (313) 559-4773, evenings. 979-2-4B

**AMERICAN PARA PROFESSIONAL SYSTEMS** seeks physicians to do basic examinations on mobile basis. Flexible hours, full or part time. Looking for physicians in Denver area and rest of state. Call: Martin Seldin, Director, (303) 758-3124, or write APPS, 2020 South Oneida Street, Suite #11, Denver, Colorado 80224. 1179-22-TFB

**WANTED:** In a world of rising costs and increasing paperwork, the benefits of Air Force medicine are more attractive than ever before. Consider an excellent income, reasonable working hours, 30 days of vacation with pay, a retirement plan that's hard to beat and the prestige and respect accorded an Air Force Officer. If you are considering a change and would like to find out more about the Air Force Medical Corps, please contact your Air Force representative at (303) 837-4525. 180-8-3B

**PRIMARY CARE PRACTITIONER WANTED** to practice on a part-time basis with another physician in a community of 1500 residents in Western Colorado. Position available September 1, 1980 with salary for first year/ up to \$20,000. Inquiries and resumes to: John B. Pelner, MD Medical Director, Mountain Medical Services, Inc., P.O. Box 1362, Telluride, Colorado 81435 180-12-3B

**NEEDED-COLORADO LICENSED PHYSICIAN** to give physical exams for national corporation. 30 hours per week. Salary negotiable. Fringe benefits. Located 60 miles from Denver. Contact: Pike's Peak Enterprises, 42 Cheyenne Mountain Boulevard, Colorado Springs, Colorado 80906, or call: (303) 475-0041. 280-8-1B

**MEDICAL PUBLIC HEALTH OFFICER.** Colorado MD license or eligible for licensure. One year graduate work in school of public health. Two years within the past ten years of public health administration. Program includes public health nursing, clinical services, Environmental Health Services, and emergency medical care. Based upon experience and qualifications, \$38,000 to \$46,000. Area covers El Paso County (Colorado Springs, Colorado), population 330,000, sixty miles from Denver, Colorado. Contact: Keith Marsh, Administrative Assistant, El Paso County Health Department, 501 North Foote Avenue, Colorado Springs, Colorado 80909. Phone: (303) 636-0102. 280-1-1B

## PROPERTIES — FOR LEASE

**FOR RENT:** 636 square feet - 2 treatment rooms and laboratory. Nice reception room and private office. \$5 per square foot includes all services and parking, central air conditioning, water, gas, air installed, located - 218 East Willamette, Colorado Springs. Call: Frank Cotten: (303) 636-1325. 1179-14-3B

**FOR LEASE:** Medical office space in Lakewood, Colorado building. Suite for one doctor and some equipment available. Immediate referrals. Call: (303) 238-4811. 579-12-TFB

**FOR LEASE:** Ideal Medical Facility site, two and one-half acres, unimproved ground on East Alameda Avenue across from Aurora Mall. Zoned AOD. Area population density increasing daily. Principals only. P.O. Box 30249, Denver, Colorado 80230. 180-1-3B

**PROFESSIONAL PLAZA** located in Southwest Denver has room for two physicians/dentists in shared clinic facilities. For lease details, please call June Bush, with Western Search Realty, Inc. (303) 393-0908. 280-2-1B

**EXECUTIVE UNIT IN VAIL CONDOMINIUM.** Available for weeks of February 15, March 7, or April 4, 1980. Private sauna - sleeps 6-10 - 2 baths - walk to ski lift and also to Vail Village shops and restaurants. Call: (303) 770-3700, Denver, Colorado, USA. 280-4-1B

**HAWAII MAUI CONDOMINIUM FOR RENT.** Two bedrooms, two baths, lanai - sleeps 4 or 5. Fully equipped, across road from beautiful beach, surf, swim, sun, snorkel, fish, etc. \$65/day. Call: (213) 673-6529 (day), or (213) 271-2263 (evening). 280-6-3B

## PROPERTIES — FOR SALE

**WASHINGTON PARK - AN AT HOME PRACTICE** priced at \$84,000. This 2,100 sq. ft. home has one thing many others don't. It is zoned for office use. If an at home practice in one of Denver's most desired areas interests you, call me, Jeanne Ruggles, at (303) 388-5903, or (303) 778-7361. 280-7-1B

FOR SALE: IDEAL PROFESSIONAL LOCATION on major highway across from shopping center, surrounded by three paved streets, ample off-street parking. Excellent location for entire Fountain Valley, near Colorado Springs. 1600 square foot house. With minor remodeling will make excellent offices. Total price only \$48,000, or cash down, and owner will carry. Your Realtor, Mary Macon, (303) 473-1112 or 473-1776. 180-11-1B

## MISCELLANEOUS

MOVING TO COLORADO? We have a super transferee information kit - Free, upon request. Write: Penny Decker, Relocation Director, Hutson Real Estate, 2731 South Colorado Boulevard, Denver, Colorado 80222, or Call: (303) 758-8821. 1179-9-6B

FOR SALE: 200MA Picker X-Ray unit, original cost \$25,000.00, only 6 years old. \$12,000.00 installed with new guarantee. 300MA General Electric X-Ray unit with image system, \$18,000.00 installed and guaranteed. Plaza Medical, Inc., 7683 E. Jefferson Drive, Denver, Colorado 80237. Call: (303) 771-6210. 180-6-3B

## SERVICES

MEDICAL TYPING DESIRED. Expert typist with background in hospital medical records transcription and doctor's office medical typing desires typing to do at home. Have own IBM Selectric II. Prefer work from South Suburban area of Denver. Can pick up and deliver work. Call: (303) 773-0775. 280-3-1B

CUSTOM KITCHEN DESIGNER will update and improve your kitchen at home. We specialize in older residential properties. We offer complete professional design and expert installation services. Please call: Yvonne Cunningham, (303) 393-0640, The Homefront, 1485 Madison Street, Denver, Colorado 80206. 280-5-1B

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# obituaries

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Doctor **John D. Pettigrew** of Colorado Springs died December 8, 1979 at the age of 45.

Doctor Pettigrew was born in Denver January 6, 1934, and attended public schools in Boulder. He was graduated from the University of Colorado in 1955 with a BA, and received his MD at the University of Colorado Medical School in 1959.

After post-graduate work at Washington University, St. Louis, he served in military medicine, and came to Colorado to serve at Lutheran Hospital, Wheat Ridge, and from 1968 to 1970 was on the faculty of the University of Colorado Medical School.

He moved to Colorado Springs in 1970 and practiced diagnostic radiology at Penrose Hospital, where he later was on the medical staff executive committee.

Doctor Pettigrew was a member of the El Paso County Medical Society, the Colorado Medical Society, and the American Medical Association. He was also a member of the Colorado Radiologic Society, the Rocky Mountain Radiologic Society, and the Radiologic Society of North America, as well as the American College of Radiology.

Doctor Pettigrew is survived by his wife Hyun, two sons, David Scott and Donald Bryan Pettigrew, a daughter, Lisa Kay Pettigrew, and his parents, Mr. and Mrs. Donald W. Pettigrew of Divide, Colorado, and a sister, C. Kay Temple of Denver.

Doctor **James H. Donald** died at Colorado Springs on December 8 at the age of 56.

Doctor Donald was born January 30, 1923 in Dallas, Texas, and was graduated from Harvard College in 1944, and from Harvard Medical School in 1946.

Doctor Donald served as chief of medicine at the then Camp Carson, near Colorado Springs from 1948 to 1950, and subsequently took a residency at Massachusetts General Hospital at Boston in Internal Medicine.

He was a member of the El Paso County Medical Society, the Colorado Medical Society, and the American Medical Society.

He is survived by his wife, Ann, a son David Homer Donald, and a daughter, Jennifer Donald Rogat, both of Boulder.

Doctor **John Louis Weaver** of Pueblo, Colorado died on January 10, 1980 at the age of 84.

Doctor Weaver was born in Concordia, Kansas where he attended public schools before going on to Kansas State University and Jefferson Medical College at Thomas Jefferson University in Philadelphia, Pennsylvania where he received his MD. He interned at Kansas City General Hospital, Kansas City in 1949-50, and took a residency in General Surgery at the same hospital from 1950 to 1955.

In 1955 he established a practice of General Surgery in Pueblo, Colorado, and was in practice until his death.

Doctor Weaver was a member of the American Board of Surgery. He served with the U.S. Army Medical Corps from March 1943 to March 1946, and in Korea from January 1951 to April 1952.

In Pueblo, he served on the staffs of St. Mary Corwin and Parkview Episcopal hospitals. He also served in Viet Nam as a volunteer physician from March 20 to May 20 in 1967.

He is survived by his widow, Frances, and a daughter, Mrs. Allison Swift, Houston, Texas, and two sons, Christian and Matthew, both of Pueblo.

## Our Cover

A child is born into a world of law, and when the child is born at home, an additional assemblage of legal aspects come into consideration. Our cover reflects the feature article by Barbara Katz on "Childbirth and the Law." Credit: St. Joseph Hospital and John Holst, Photographer.

## Colorado Chest Physicians Named Fellows

Among 150 physicians and surgeons conferred with Fellowship status in the American College of Chest Physicians during the 45th Annual Scientific Assembly of the organization in Houston, Texas are Thomas S. Moulding, MD, Charles H. Scoggin, MD, and Joseph Snyder, all of Denver.



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Address all correspondence relating to subscriptions,  
advertising or address changes, manuscripts, organi-  
zations and other news items relating to editorial  
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Editorial and Business Office  
1601 E. 19th Ave.  
Denver, Colorado 80218  
Telephone (303) 861-1221

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*Colorado Medicine* (ISSN-0035-760X) is published monthly for \$12 per year by  
the Colorado Medical Society, 1601 East 19th Avenue, Denver, Colorado, 80218.  
Second-class postage paid at Denver, Colorado. POSTMASTER: Send address  
changes to *Colorado Medicine*, 1601 East 19th Avenue, Denver, Colorado 80218.

ht: 1980 by the Colorado Medical Society. All material subject to this  
ht appearing in *Colorado Medicine* may be photocopied for the noncom-  
purpose of scientific and educational advancement.

Advertising: National representative: John H. Harling, Inc., 8 South Michigan  
Avenue, Chicago, Illinois 60603. Telephone: (312) 641-9755.

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# president's letter

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## The Hospital Commission is dead!

As your president, I fully concur with the consensus of the membership; however, as an individual I have some reservations. Be that as it may. We, as a group, now have a responsibility to the public to make a real and visible effort to contain the costs of medical care. All of us, the AMA, CMS, third-party payers, and a host of health-care providers have responded to the public outcry over medical costs.



There is no single answer to this problem. I won't even attempt to analyze the problem. I will, however, reiterate a long-held belief which has been difficult for me to express:

We, as physicians, have become more and more dependent upon utilization of sophisticated analytic technics. Witness: the evolution of the CT scanners, mammography and a host of analytic tissue measurements. Every day we learn about another test. There have been the growing pressures of the threat of malpractice to utilize these so-called "standards of practice." More important, though, is the concern we, as practitioners, must have to practice the best medicine possible. How can we apply

ourselves to a conscientious effort of cost-containment? Personally, I say it is simple: I say to myself "Based on my knowledge and my practical experience, is this procedure really necessary to the case at hand?"

On a related subject I would like to repeat what I said in my remarks to the just-concluded House of Delegates session in Denver: The University of Colorado School of Health Sciences is undergoing changes which could... I say *could*... have serious effects on the quality of that institution, long regarded as one of our nation's finest schools of medicine. The concerns are not just those of the newly-appointed Dean, **Roy Schwarz, MD**; they are the concerns of the entire physician population of Colorado. We, as professionals, must stand in support of this institution and what it means to the practice of medicine. We cannot let the divisiveness created by *style* versus *substance* destroy this one fine institution. We cannot stand by and let individual *styles* of some of those departing faculty members be the determining factor in the future *substance* of the teaching of medicine in Colorado. We must, as a Society, continue to offer **Dean Roy Schwarz** the support of our membership, to provide the stewardship to continue the excellence of teaching and public service of the University of Colorado School of Health Sciences. We, the knowledgeable, experienced practitioners of Colorado, must avail ourselves of the primary teaching institution and its leadership, ready to lend our knowledge and experience in support of its continuance as one of the best such schools in the United States. I, personally, have committed myself to that end, and I ask that you, as a Society, would do that also.

*Roy S. Schwarz*

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## CME Hospital Accreditation

On-site visits to a number of Colorado hospitals by the Continuing Medical Education Division of the Colorado Medical Society have resulted in re-accreditation of CME programs in certain hospitals as well as first-time accreditation of other hospitals.

This vigorous program of studying the ability of hospitals to carry out programs of quality has been a major thrust of CMS in recent years.

Among these hospitals are two receiving the recognition for the first time, the Aspen Valley Hospital and St. Francis Hospital at Colorado Springs. Dr. H. C. Whitcomb serves as Chairman of the Aspen hospital's Medical Education Committee, with Judy Schwalbach as Medical Education Committee assistant and coordinator. Its accreditation was received in November.

The St. Francis Hospital was accredited in November. Dr. David H. Huffman is Director of Continuing Medical Education at this hospital.

Three hospitals received renewal of accreditation. These are St. Joseph Hospital, Denver, Dr. C. Houston Alexander, coordinator of CME; Poudre Valley Memorial Hospital, Fort Collins, Dr. Peter J. Standard, chairman of the CME committee; and Colorado State Hospital, Pueblo, Dr. James H. Scully, Director of Professional Education.

### Rea Named Parkview Chief

John Joseph Rea, MD, radiologist of Pueblo, Colorado, has been elected to be chief of staff at Parkview Episcopal Hospital at Pueblo.



# at press time ...

## HIGHLIGHTS OF JUST-CONCLUDED COLORADO MEDICAL SOCIETY WINTER CLINICS AT DENVER

The following is a brief summary of the actions taken by your House of Delegates at the Winter Clinics, 1980, which closed on Sunday, March 2:

...Approved an expenditure of up to \$3,500.00 to support the Colorado Medical Society Auxiliary's Health Educational Project.

...Approved a news media awards program. Awards, in the name of Robert Perkin, will be paid to editors of radio, television and print news media for outstanding medically related reporting.

...Approved expenditures of up to \$2,500.00 to cover per diem and transportation costs during the organizational stages of the Impaired Physicians Program.

...Approved expenditure of \$4,653.00 so that CMS may enter into the AMA/LEAA Jail Project grant.

...Approved distribution of \$12,055.40 interest income from the Colorado Medical Foundation Trust to 501-(C)(3) charitable organizations: Amigos de las Americas, Hall of Life, Colorado Heart Association, and Colorado Diabetes Association.

...Approved new concept for Colorado Medicine.

...Approved standardized immunization form proposed by the Governor's Immunization Action Committee.

...Approved creation of a category of rate classification under CMS/Hartford program for family practitioners involved in giving general anesthesia for elective cases.

...Accepted report that the Public Information Committee is developing a brochure containing tips and information, as supplied by "your doctor," to promote good health cost containment recommendations.

...Acknowledged efforts of Communication Director in securing knowledgeable spokesperson to respond promptly and decisively to public issues.

...Staff directed to initiate membership recruitment and retention program.

...Encouraged continuous input from membership re issues of concern to CMS by utilization of inquiry/response medium through Colorado Medicine.

...Encouraged use of CMS Legislative Hot Line as means of dissemination of legislative news and Medical Society interests.

...Approved participation by CMS in a series of radio programs dealing with health and medical care issues being initiated jointly by CMS and the Burroughs-Wellcome Company, and to be sponsored, jointly, by CMS and by Component Societies, with editing and production being done by CMS staff.

## HIGHLIGHTS OF WINTER CLINICS (Continued)

...Received report of Professional Liability Committee, Risk Management Committee and Special Committee for Negotiations.

...Noted staff relocations within headquarters building.

...Noted updated and revised staff organization by Executive Vice President.

...Clarified Board/Staff relationships.

...Noted that CMS has withdrawn from the Western Physicians Purchasing Association.

...Charged the Constitution, By-Laws and Credentials Committee to work in concert with the Organizational Study Committee to review CMS By-Laws and recommend necessary changes to Annual Session, 1980.

...Urged continued attempts to avoid scheduling of meetings of the Board of Trustees and administrative councils in conflict with scheduled meetings of component medical societies.

...DIRECTED the Special Committee for Negotiations to represent all segments of Colorado Medical Society fairly and without prejudice.

...Referred the study of malpractice premium rates for part time physicians to the Risk Management Committee.

...Directed the Board of Trustees to investigate and carry out the most appropriate means to secure adequate immunity for grievance committees of component medical societies.

...Received the report of the Judicial Council which again requested that component medical societies give input into the final report to the AMA in their consideration and possible revision of the AMA Principles of Medical Ethics.

...The Grievance Committee continues to be active in the adjudication of problems in the community; the Committee is maintaining a policy of complete confidentiality regarding complaints and their resolution.

... House of Delegates received a report of the 1979 AMA Clinical Meeting, in which the AMA reaffirmed its position on National Health Insurance embodying the four principles of: (1) Requiring minimum standards of adequate benefits in all health insurance policies sold in the United States with appropriate deductible and co-insurance; (2) A simple system of uniform benefits provided by the federal, state and local governments for those individuals who are unfortunate enough not to be able to provide for their own medical care; (3) A nationwide program by the private insurance industry of America to make available catastrophic insurance coverage for those illnesses where the economic impact of a catastrophic illness could be tragic; and (4) A program developed pursuant to those principles should be administered at the state level.



## HIGHLIGHTS OF WINTER CLINICS (Continued)

...House of Delegates conferred Honorary Membership in Colorado Medical Society upon the following:

M. Roy Schwarz, Dean, University of Colorado School of Medicine.

Lawrence M. Wood, Attorney, Legal Counsel for Colorado Medical Society.

...Received CMS Policy regarding Physician's Assistants - revising the 1975 COLORADO MEDICAL SOCIETY GUIDELINES FOR PHYSICIANS EMPLOYING PHYSICIAN'S ASSISTANTS, defining "Supervision:"

REPORT OF: Reference Committee on Interprofessional Relations

(Excerpt) (AMENDMENTS SHOWN IN SCRIPT) (DELETIONS SHOWN BY STRIKE-OUTS)

### RECOMMENDATION:

Page 5, Section d. making the following deletions and additions:

"The licensed physician must provide adequate supervision ~~of the performance of delegated medical services~~. AS DEFINED IN THE 1975 COLORADO MEDICAL SOCIETY GUIDELINES FOR PHYSICIANS EMPLOYING PHYSICIAN'S ASSISTANTS (LM/BT-2, Addendum No. 1, Page 1, No. 5).

"SUPERVISION - RELATES TO THE DEGREE OF PERSONAL GUIDANCE PROVIDED BY THE RESPONSIBLE PHYSICIAN. THE MEDICAL PRACTICE ACT STATES: 'THE RENDERING OF SERVICES UNDER THE PERSONAL AND RESPONSIBLE DIRECTION AND SUPERVISION OF A PERSON LICENSED UNDER THE LAWS OF THIS STATE TO PRACTICE MEDICINE' SHALL NOT BE CONSIDERED THE PRACTICE OF MEDICINE.

"A. DIRECT SUPERVISION - THE EMPLOYING OR RESPONSIBLE PHYSICIAN MUST BE AVAILABLE TO HIS ASSISTANT IN PERSON OR WITHIN THE SAME OFFICE OR HOSPITAL. THIS IMPLIES ONGOING COMMUNICATION BETWEEN THE PHYSICIAN'S ASSISTANT AND THE PHYSICIAN.

→ or responsible

"B. INDIRECT SUPERVISION - THE EMPLOYING / PHYSICIAN, ALTHOUGH NOT IMMEDIATELY AVAILABLE TO THE ASSISTANT, MUST HAVE A PRE-ARRANGED PLAN OF ACTIVITY OR TREATMENT FOR THE SPECIFIC PATIENT PROBLEM WHICH THE ASSISTANT MAY CARRY OUT IN THE ABSENCE OF ANY COMPLICATING FEATURES *and be immediately available by telephone or other electronic means.*

*or responsible*

"IF THE EMPLOYING / PHYSICIAN IS UNABLE TO DIRECTLY OR INDIRECTLY SUPERVISE THE ACTIVITIES OF HIS ASSISTANT, HE MUST MAKE ARRANGEMENTS FOR ANOTHER ~~PRIMARY~~ CARE PHYSICIAN *of appropriate training* TO ASSUME THE RESPONSIBILITY FOR THIS SUPERVISION OR TEMPORARILY SUSPEND THE PRACTICE ACTIVITIES OF HIS ASSISTANT.

"TO QUALIFY AS A PROPER SUBSTITUTE, THE PHYSICIAN MUST BE FAMILIAR WITH THESE GUIDELINES AND WITH THE TRAINING, CAPABILITIES, AND LIMITATIONS OF THE PARTICULAR PHYSICIAN'S ASSISTANT AND BE WILLING TO ASSUME ETHICAL AND LEGAL RESPONSIBILITY FOR DIRECTION OF THE ASSISTANT'S ACTIVITIES AND CARE OF THE PATIENTS HE SEES." Supervision is intended to assure that the directions given are carried out properly. ~~Supervision may include constant over-the-shoulder inspection of the performance of the medical services, after the fact review through viewing the patient or his chart or conferring with the non-physician health care provider rendering the delegated medical services.~~

## HIGHLIGHTS OF WINTER CLINICS (Continued)

...The House of Delegates DIRECTED the Board of Trustees to continue developing a program toward definition or certification of PAs according to the qualifications of a generic P.A.

...Received the report of the Council on Interprofessional Relations with recommendation and copy of letter to FDA and congressional representatives outlining the concerns of Colorado Medical Society about patient package inserts.

...Council on Interprofessional Relations continues prime emphasis on allied health professionals, e.g. Joint Practice Committee re Nurse Practice Act, etc. Future emphasis to be on liaison with other voluntary organizations with CMS increasing its efforts toward a positive stature.

...Noted that the Council on Legislation is placing emphasis on communication with the membership and providing information about the importance of their political involvement at all levels of government.

...Recognized the Colorado Medical Society Auxiliary efforts to educate the Auxiliary membership in various aspects of the regulatory and legislative process.

...Inter-Council Relationships have been strengthened. Legislative issues requiring a CMS position are assigned to the appropriate administrative council for study and recommendations prior to any decision by the Council on Legislation. Issues requiring a policy statement are referred to the Board of Trustees.

...Council on Legislation activity centered around a series of bills dealing with health insurance for the medically indigent, changes in the Nurse Practice Act and increase in student tuitions, hazardous waste disposal, and increased salaries for state-employed physicians.

...Supports legislation changing 1942 ceiling on salaries for physicians employed by the State of Colorado.

...Received the report of the Council on Medical Services re activity in all aspects of, and facilities for, the delivery of medical service.

...Received the Hospital Categorization Report which was subsequently recommended for filing.

...Noted the Committee on Medical Care in Correctional Institutions has been actively working with the Colorado Department of Institutions and Department of Corrections to assist in the improvement of the quality of medical care in Colorado's correctional institutions and jails.

...The Committee on Alternative Health Care Ideologies has been newly organized and will review and study various ideologies for non-traditional methods of health care delivery and report to the CMS membership in the coming year with their evaluations dealing with the concept of wellness.

...Noted the Rural Health Conference, co-sponsored by the Colorado Medical Society, continues to be a proven and successful tool toward improving communication between community members, both health professionals and consumers, regarding rural community health problems.

...Noted the Long Term Care Committee continues to be actively involved working on acceptable proposals to deal with problems in long term care.



## HIGHLIGHTS OF WINTER CLINICS (Continued)

...Noted that the Committee on Health Education and School Health continues to monitor the progress of proposed changes in rules and regulations for the Handicapped Children's Education Act and the Robert Wood Johnson Project, which supports demonstration programs in health education and school nurse practitioner services. The Committee attention is also focused on potential support for a proposal to Colorado Legislature, requesting moneys to implement school health education.

...The Committee on Private Health Insurance called attention to the fact that frequently an impasse is reached concerning the charge and obligation of the Committee to provide a mechanism for investigation of health insurance claims versus the risk of violating anti-trust and Federal Trade Commission regulations. This committee is continuing to work with the Special Committee for Negotiations or the Grievance Committee on any problems requiring their action, and will continue to review all aspects of third-party reimbursement, and work to study the creation of an arbitration tool in the coming year.

...The Committee on National/Catastrophic Health Insurance focused its attention on proposed health care financing options for Colorado. The Committee developed a statement of policy concerning the problem of underinsurance and medical indigency in Colorado. Policy determination in the area of medically indigent insurance programs constitutes a priority consideration in the area of tax credit or deductions for medical care, and will continue to provide input into any proposed statutory policy by the legislators.

...The Board of Trustees directed the Council on Socio-Economics to study the collapse of ChoiceCare, a health maintenance organization based in Fort Collins, Colorado. This study is to be undertaken by the Committee on HMO/IPA.

...The House of Delegates adopted a resolution re Physician Participation in Medicaid Program, which states: "RESOLVED, that the Colorado Medical Society will strive to assist such disadvantaged citizens through both the private and public sectors, and be it further RESOLVED, that the Colorado Medical Society volunteer its participation to work with the Colorado Department of Social Services in a creative fashion to effect significant improvements in the Medicaid program, thereby encouraging increased physician participation."

...The House of Delegates adopted a resolution stating that the Colorado Medical Society go on record as continuing to support voluntary efforts as the most desirable mechanism for attempting to control rising hospital costs.

...The House of Delegates adopted a resolution to alternate the Annual Sessions between the Broadmoor Hotel and Keystone, beginning with the 1981 Annual Session.

...The following were elected to serve as the Nominating Committee:  
Robert Dingle, M.D., District IV; Robert Hartley, M.D., District I;  
Joseph Pollard, M.D., District III; Ken Nelson, M.D., District V; and from District II: Tony Palmieri, M.D., Adams County-Aurora; Frank Sargent, M.D., Arapahoe; Stanley Sontag, M.D., Clear Creek Valley; Edward Rhodes, M.D., Denver; Alan Stormo, M. D., Boulder.

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# condensed minutes

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1. Approved the minutes of the Board of Trustees meeting of January 11, 1980.
2. (A) Received the informational report of Ray G. Witham, M.D., President.  
(B) Approved the report of the Finance Committee, the Balance Sheet and Check Register.

Approved \$300.00 for School Health Project (included in the budget).

Approved Dr. Bowling to represent the Society at the National Pharmacopoeial Convention, at his own expense; requested a written report.

Approved the revised budget.

- (C) Council Liaison Reports;  
Heard reports from Drs. Howard, Kauvar and Lewis.

- (D) Heard report re CFMC Long Term Care project, presented by Kenneth A. Kahn, M.D., Associate Director.

- (E) District reports: Positive report re CMS activities and involvement from Dr. Davis in District V; Report of CFMC concerns, re reimbursement, from Dr. Linnemeyer, District V.

3. Assigned Board of Trustees members to attend Reference Committees.  
Drs. Brusenhan and Schwyzer changed.

4. Lengthy discussion on paper presented by Dr. Witham, entitled "Criteria for Establishment of CMS Policy."

Approved motion to reiterate policy on meeting attendance for council and committee meetings. (Two unexcused absences.)

Approved recommendations (1) The Board of Trustees approve or disapprove all Council recommendations as reported by the Council chairmen; (2) In the event the Board of Trustees cannot meet, the Council's recommendations be approved or disapproved by the Executive Committee; (3) In the event the Board and the Executive Committee cannot meet, CMS Staff will act with concurrence of Council Chairman.

Further, Refer this Policy for establishment of CMS policy to the Organizational Study Committee for consideration, or to change By-Laws.

Approved motion to recommend to the OSC to consider changing the name of the Board of Trustees to the Board of Directors.

5. Report of Special Committee for Negotiations presented by Dr. Sankey, Chairman. Motion approved for Special Committee for Negotiations to represent the CMS on the Department of Social Services' newly-formed committee. "Physician Community and Department of Social Services Committee includes representatives from CMS, Blues, Medicaid, CUPS, and Presidents of Ob-Gyn, Pediatrics, Family Practice and Internal Medicine."

6. Board met in executive session and received report from Drs. Brittain, Johnson and Mahoney.

Discussed Benefit Package for EVP.



# A Colorado Country Doctor

Jeanne Mills Varnell, Lakewood

The life led by William McConnell as a country doctor at the foot of the Rampart Range, where breathtaking vistas exhilarate and raw weather everlastingly torments, is recalled in letters by his daughter, Frances McConnell-Mills, MD, and in his journals and papers as rugged in the extreme yet gratifying in the personal satisfactions of trying to provide quality medical service in that often rough land.

From 1880 to 1915 Dr. McConnell lived in Monument, first with his parents who moved the family from Missouri, then with his own family until his move to Denver to join the Army Medical Corps at the time of World War I.

McConnell was twelve when he came to Colorado. Because of his mother's asthmatic condition, his father sold his large Missouri farm to purchase 500 acres near Table Rock in El Paso County, where he built a farmhouse to house the family with its nine children. The family traveled by wagon rather than train to this new home, so that a gradual rise to the new altitude could be arranged. McConnell remembered late in his life that as a boy he had driven one of the wagons.

William was oldest of the boys, and the second child. He helped with crops and livestock, and in the barn he had a separate stall where he used poultices and bandages and acknowledged home remedies to care for injured and sick farm animals and some wild animals.

The young boy learned early about extending care to the less fortunate, as he went about the countryside with his mother, tending the sick and injured.

William was graduated from Table Rock School when he was 16, and then he went to Denver to attend Warren Academy, the preparatory school maintained by the University of Denver. In varying succession he was janitor, a clerk with the Durbin Surgical Supply, and a typist at the U.S. Patent Office. He continued through the University of Denver, earning a pharmacology degree, then entered the School of Medicine which was then under the Univer-

Fig. 1. William McConnell around the time of his graduation from the University of Denver Medical School.



sity of Denver. He was graduated as an MD in 1892.

McConnell was fascinated by medical school, even though he worked after school, and studied long hours every night. Because of his long interest in animals, shown by his caring for those sick and ailing animals on the farm, he continued to compare animal and human structures as he studied human cadavers.

Many years later he recollected for his friends and family how cemeteries were raided for dissection subjects, although he never admitted that he had ever been along.

Many new subjects were taught. Because of the great number of unrelated drugs, pharmacology was complicated. Bacteriology was very elementary. The fraudulence of former subjects like physiognomy and phrenology was being unveiled, but had not entirely been stopped in academic courses.

McConnell considered himself fortunate in having Dr. J. N. Hall as a professor in the field of physiology. Students were sent to Denver Charity Hospital to learn how to observe patients, take histories, and study palpation and auscultation with this very quiet but keen doctor.

Students had ample experience in practical medicine during their last year of medical school, as they were scheduled for much time in outpatient clinics, in the hospital, and in obstetrics. As it was then believed better practice for childbirth to take place in the home, it was arranged that two students would be sent to a home at the first call, and when a delivery was imminent, they would call the obstetrician. Invariably there were times when McConnell and the student with him were obliged to handle the delivery on their own.

Mrs. Varnell is a journalist, and granddaughter of Dr. McConnell, and is the daughter of Frances McConnell-Mills, MD, as well as brother of David McConnell Mills, MD of the Texas Tech University School of Medicine, and mother of Jeffrey Lee Varnell, MD, a resident at the Truman Memorial Medical Center, Kansas City, Mo.

It seemed that Charity Hospital, St. Louis, with its older traditions was the place for his internship. Immediately after completing this experience he opened a St. Louis office. After a year of city medicine he concluded that he was a country boy at heart, and that he could work better with the country people back home, so gave in to this combination of love for the front range and the touch of homesickness, and returned to Colorado.

As soon as he had raised sufficient funds he bought a practice from an elderly Monument physician, ten miles from the family ranch. This practice had included a combination store and living quarters on Main Street, next to the pool hall. He sold these structures, and bought a farmhouse up the street. There being no drugstore in Monument, McConnell kept his own supplies and drugs.

He did need modern offices and facilities, so in 1896 with his brother Wythe's help, he built a brick drugstore with two offices, a large storeroom, a small workshop, and a cellar where a hot air furnace was installed. Because it offered a soda fountain and candy counter, as well as cosmetics, cigars, and a prescription drug department, the new store became a very popular Monument gathering place, and before long McConnell had to hire a pharmacist to run the store.

Getting a practice established was a different, slower story. McConnell was a strong, sturdily built man with wide blue eyes, and curly, sand-colored hair, and the kind of man easy to like. Since he was a native as far as most of the residents were concerned, they took an immediate liking to him. But as a bachelor, there was a reluctance on the part of the farm women to have him attend them at childbirth.

A break came when a Mrs. Dalton was due, and sent word to the older Monument physician to come for her delivery. As pains increased and hours passed, no Older Physician arrived. Her husband went up the road to find what the delay was, and noticed the familiar horse and buggy meandering about. Going on to Monument, the farmer found the young bachelor doctor, McConnell, and asked him to come. On their way back they encountered the Older Physician drunk in a ditch, and put him into the buggy. After assisting in the delivery, McConnell examined him to find he was merely heavily hung over. Thanks to the Daltons, McConnell soon had a flourishing obstetrics practice going.

An old bicycle served McConnell in town, but for more distant calls he rode Brownie, a saddle horse. In his second year at Monument, he acquired a light buggy as a more dignified means of travel. The first day he had the buggy he stopped at a well to water Brownie. Suddenly, she jerked loose and raced downhill, upsetting the buggy, kicking off the harness, and galloping off, disseminating pills and capsules across the front range.

It was not easy to summon a doctor in Monument. Farmers usually walked or drove wagons into town, and in an emergency would load the fever-ridden or injured patient in the wagon and get going. Those living near railroads would wire for help, and sometimes handcars out on railroad business would deliver word of medical need between block stations.

Colorado Springs had the nearest hospital, so only critical cases went there. Rather than bump patients along rude country roads, McConnell preferred to perform operations of even some difficulty on a farmhouse kitchen table under dim lamplight.

Early one morning, McConnell responded to a call to attend a pneumonia case. He followed the husband of the ailing woman through the wind-driven snow, squinting to see where he was going. When they arrived at the farmhouse, Mrs. Harvey was nearing a crisis, one such as many McConnell had seen, and knew how to treat.

He threw open the bedroom window, covered Mrs. Harvey's head with a shawl, ordered some bricks heated in the oven for her feet and placed mustard plasters on her chest and back. He had brought cariac stimulants in case they should be needed at a yet more critical time. Since Mrs. Harvey breathed with difficulty, he coaxed down a teaspoon of cough syrup, and by dawn she was resting, the crisis having passed. Mr. Harvey in thanks offered to send McConnell a side of a hog or steer in payment.

Such treatment was the forerunner of the oxygen tent, and it was one of the many ways in which McConnell combined medical knowledge with imagination and intelligence to care for the simple ranch and small town folk along the Rampart Range.

It was another way in which McConnell acquired a reputation among Colorado doctors for having a quite phenomenal success with difficult pneumonia cases. Prominent Denver doctors often consulted with him, and he intro-



duced them to the fresh air treatment, with a fire keeping those attending the patient comfortable.

Other doctors were at this time referring to a book on "Practical Therapeutics" which was published in 1891, and which recommended bleeding, leeching, cupperry, and cardiac stimulants such as strychnine in early stages of pneumonia. Ice poultices, as well as mustard plasters and pepper dosages were urged. In a discussion of diphtheria, no mention is made of antitoxins, though trachiotomy is recommended as a means of preventing suffocation.

There lived a family of recent English origin, the Prings, three miles south of Monument. Their daughter, Lucy, was widely considered the prettiest girl in the county. A teacher at the Pring School, when she was thrown by her horse, her father took her to Doctor McConnell.

The doctor cared for her during recovery, and continued over many years to care for her after they were married on June 22, 1898.

To provide the best, Dr. McConnell built a windmill over the deep well behind the old house, and placed a water storage tank on the coal house, then piped water into the kitchen and into a bathroom — the only one in town with a tub. As the pipes passed through the firebox on the kitchen range, the water was heated.

In 1899 several smallpox cases were observed among the railroad crews, so McConnell vaccinated everyone he could, and instructed mothers how to vaccinate their children. By the spring of 1900 he was still treating patients for smallpox. One night he came home late, and refused to let Lucy come into the office with him. He locked himself in, exhausted, burning with fever, and told her he had a touch of smallpox but would probably not have a serious case of it.

Adamant in his determination to stay in isolation, he slept heavily for 48 hours. Upon awakening he felt refreshed and definitely improved. There were no traces of pox on his skin, so he allowed his brother, Wythe, to bring him some food. In another two days he was back at work. In 40 years of medical practice this was one of the few instances in which he lost any time to illness.

There was really no way to transmit a call for help along the Rampart Range, it was widely recognized. Finally, in 1906 a few telephones were connected to Monument, one being in McConnell's Drugstore. With this to start on,

McConnell and some friends decided to string barbed wire on poles from the Santa Fe Depot, east of town, to the first fenced field beyond. The telephone line was run along the top strand of the barbed wire fence, and at gateways was raised on poles.

At first, there were very few subscribers east of Monument, but soon there were nearly thirty telephones. Each family had its own ring, and the ring would be heard in every one of these homes. The call for the doctor came in as a long ring, two short rings, and a second long ring. In bad weather calls had to be relayed from farm to farm until the doctor was reached. Even so, this was faster than going by horseback in raw weather.

When heavy snows drifted over the wires, they would silence the lines. Then McConnell would ride the fences east of town to dig the fallen wires free. Presently, as the telephones extended outward from Monument, an exchange was established in Higby's General Store, which provided central switching for three main lines, all of which rang in the doctor's office. He installed his own system for switching from one line to another.

By the end of his first year, McConnell had contracted to care for employees of the Denver and Rio Grande Western railroad in the area. Soon he was attending families within a 15-mile radius, including farm families, section hands, station masters, townspeople, and the residents in the nearby resort, Palmer Lake.

Spanish Americans who spoke little English made up the railroad crews. McConnell became familiar with them and their speech, and learned a workable Spanish-English dialect so that he could help their family and financial problems.

Among the section hands were some destitute families who lived in box cars furnished by the D & RGW. One day Doctor McConnell was called to Palmer Lake where he found a woman lying in a box car on an old coat in early labor pains. He was not prepared to assist until he had returned with sheets, blankets, and a layette.

While a neighboring woman watched over the mother-to-be, McConnell made preparations and returned to deliver a healthy child, born in the early hours of the morning. Two days later when he stopped to make his first postnatal call, the new mother was outside washing clothes in a scrub bucket.

One night following a dance a saloon brawl

broke out, and a farmer was killed. Immediately McConnell was called, and he took charge until a deputy sheriff arrived. A hot-tempered French Canadian was the murderer, but he had fled the scene, and until well into the following day he was the object of a strenuous manhunt until he was found.

Sides were taken because some thought there was sufficient provocation, even though all agreed on the actual killer. McConnell was called to testify on the cause of death, and the circumstance at the scene of the crime, stating that the victim had died about two minutes after he had arrived there.

For some reason the defense attorney questioned the time factor, and asked if there could be a mistake about the two minutes — could it have been ten minutes? McConnell affirmed that two minutes was quite correct, whereupon the lawyer drew a big watch from his pocket, and directed the doctor to tell him when two minutes had passed. McConnell sat quietly with his hands in his lap, and in exactly two minutes announced the time was up. A guilty verdict was handed down.

McConnell told intimates that he had counted his pulse as he sat in court, trying to allow for a more rapid than usual rate due to his excitement.

The first big train wreck in the area took place in 1908. The tragedies of early day train wrecks were personal for McConnell in this instance, as he had been attending in childbirth a Mrs. Gossman, wife of the Santa Fe agent, when the terrible sound of trains crashing head-on was heard, just after the infant was born.

As soon as possible McConnell went to the

scene of the crash, finding that among the dead was Gossman, father of the new baby. There were many dead, and many injured for whom care was immediately required. For many hours he volunteered his help, preparing the injured to go to hospitals in Colorado Springs and La Junta.

In 1910, two years later, another wreck took place at Dirty Woman Gulch, south of Monument, when timbers of a high trestle over the Gulch gave way under a passenger train. Several passenger cars fell into the gully, and the cars that had not fallen teetered on the track. Miraculously only three deaths occurred in this disaster, but there were many injuries, as well as the hysteria of the uninjured trapped in swaying cars. McConnell and the other Monument doctors worked throughout this emergency.

After eight years of practice in a remote community, McConnell realized he needed more advanced knowledge of traumatic surgery to treat the injured section hands and farmers, so with Lucy and baby Frances he went to Chicago for a year's surgical training at Rush Medical College.

While there he also studied two new technics for treating diphtheria. A terrifying outbreak of diphtheria the following winter showed this to have been fortuitous. One technic he learned was use of the newly developed antitoxin; and with a small supply he was the first in Colorado to use it. However, the sickness spread, and supplies were always too small.

Any simple respiratory ailment quickly turned into diphtheria. In one household, the children, though ailing, seemed to have only benign infections. Shortly after he had been to see this household one young child appeared to have worsened, and came down with diphtheria.

As McConnell arrived at the Husted Depot to wire for more antitoxin the station agent spotted him, and gave him this news. Shortly after McConnell's arrival at Monument the antitoxin arrived by train from Denver, and he immediately went to treat the child.

When a five-year old boy turned blue with diphtheria, McConnell, who had driven across six miles of blizzarding snow at the call of the father, flamed his scalpel and immediately cut through the trachea just below the larynx, to perform one of the first successful tracheotomies to be recorded in Colorado. Injecting a syringe needle, he aspirated the ac-



Fig. 2. Years ago this painting was done of the McConnell home at Monument.



cumulated fluid until the child gasped for air, whereupon he inserted a tube, and instructed the mother to prevent it from clogging. At the time there was no toxin on hand, but its later arrival from Chicago hastened the child's recovery. That child grew to be a well known member of the Monument community who often displayed the scar of his tracheotomy with gratitude.



Fig. 3. The people of Monument would call their children off the streets when Dr. McConnell's Model T was seen racing along the way at 15 MPH!

There were days when McConnell would set out early in the morning, drive all night, and sometimes remain with patients for as many as three days to see them over a crisis. He would find a spare bed in a farmhouse, rest, and start out again, only to find a patient, nearing a crisis of pneumonia, with whom he would stay all night.

By now the automobile was supplanting the buggy as a reliable means of getting around, and Doctor McConnell became intrigued enough to go to Denver to buy a Ford. That car was something to see. It was a black roadster with brass trim, but no door. The back seat was bolted to a wooden tool chest which contained tools to convert the car to a touring car. The top could be unfolded and strapped to the windshield, and intricate isinglass curtains buttoned into place.

McConnell's Ford was the first in Monument. It was said that after it arrived in town, when farmers heard the doctor's phone ring, they hurried to get their children off the roads and tie up the horses. At any time McConnell's Ford might come tearing down the road at 15 miles per hour.

There were times when a patient too ill to be home would be kept in the back office under the care of both McConnell and Lucy; their three daughters assisted in these in-house duties.

They were all taught at home until old enough to attend school. Frances, who was developing a medical curiosity, akin to that characterizing McConnell's adolescent years, often went along on calls with him.

Later Frances won a scholarship to the University of Denver, and worked her way through the University of Colorado School of Medicine. She eventually became Denver's city toxicologist, a pathologist at Denver General Hospital, and St. Luke's Hospital, and the Colorado Department of Health.

Her son, David McConnell Mills, also a graduate of the University of Denver and the University of Colorado School of Medicine, practices and teaches as professor of Rheumatology at Texas Tech University. William McConnell's first great grandchild, Jeffrey Lee Varnell, was graduated from the University of Colorado School of Medicine, and now is a resident in surgery at Truman Memorial Medical Center at Kansas City, Mo.

At the turn-of-the-century, the Reverend John Leyda, a Presbyterian minister, served Monument and Table Rock. His two teen-age sons often were found at the drugstore, asking questions of the doctor, learning about medicine, and sometimes following him on rounds.

They admired him greatly. McConnell, impressed by their dedication, assisted both by providing interest-free loans for their education. These were the first of 17 young men and women given such scholarships by Dr. McConnell, and they headed a group of eminent Colorado physicians. Eventually the loans were repaid.

One beneficiary, Dr. Broda Barnes, now of Fort Collins, recalled that as a boy he stopped by "Doc" McConnell's office, and saw him as "just a country doctor. He sat in his big swivel chair and always took time to listen. He was infinitely patient."

When Dr. Barnes retired after a long Denver and Fort Collins medical practice, he endowed two college scholarships, the William McConnell Scholarship, which provides interest-free revolving loans for young men and women at the University of Denver chemistry department, and a second scholarship at Rush Medical College, Chicago, which honors both Dr. McConnell and Dr. Reuben Gustavson, a former medical professor there. ●

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## letters to the editor

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Two movements within the past month call for Colorado Society members' acknowledgement: (1) Nurses are meeting, marching, and petitioning for fair pay for their services, and (2) many educators, researchers, and clinicians have left the University of Colorado Health Sciences Center, and another 100 might soon follow them.

Lack of space prevents a balanced reporting of the issues involved. Without that report we cannot make intelligent judgments. A few conclusions, however, can be summarized.

- The citizens of this city and state show decreasing support of medicine.
- Medicine should (1) practice more effectively, (2) close ranks, and (3) negotiate its causes more clearly and persuasively.
- Differences that divide us can and should be overcome. For example, the "Town vs. the Gown"; surgeons vs. physicians, etc.
- The functions of the county and state societies are not for a select few committee members who are on "ego trips." Perhaps not all of us are "chiefs," but certainly we are part of the "tribe."
- The practice of medicine is vulnerable in many areas. Nurses and educators are but two recent examples of this vulnerability. Why have we chosen a career in medicine? Reevaluation of and re-dedication to our ideals is long overdue. Continued drifting makes us still more vulnerable.
- The Divide and Conquer Tactic. If we cannot cope with this (Divide and Conquer) approach, then it is truly an "after us the deluge" situation.

Raymond A. Vercio, MD

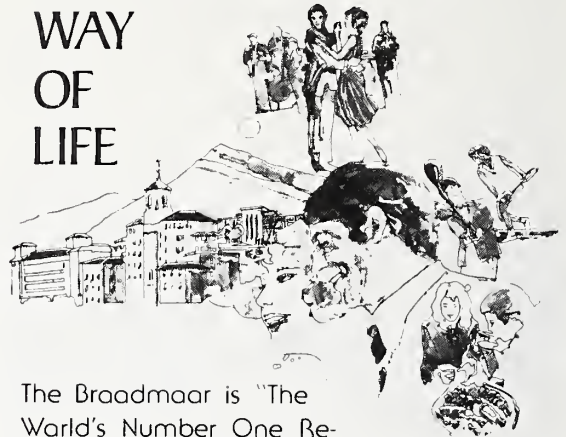
Denver

### Tubergen to Chair Committee

David G. Tubergen, MD, director of oncology-hematology at The Children's Hospital, and associate professor of pediatrics at the University of Colorado Health Sciences Center, has been named to chair the medical advisory committee of the Colorado Leukemia Society.

Dr. Tubergen will supervise seminars, symposiums, and activities of the Society.

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# Denver-Born "CanSurmount" Program Enters Its 7th Year

CanSurmount, an American Cancer Society patient service program which originated in Colorado, was this past year adopted by the national parent organization for all Divisions of the society.

The announcement of the expansion of the program was made a year ago by Howard F. Bramley, MD, president of the Colorado Division, American Cancer Society.

At the one-year anniversary of the program's national adoption, here are some of the facts concerning the development of the program and its originator, Paul K. Hamilton, MD, Denver oncologist.

Dr. Hamilton tells *Colorado Medicine* that the idea of CanSurmount was first conceived as a cancer patient visitation and counseling program in 1973. Dr. Hamilton's motivation was the effort to help cancer patients and their families better understand and cope with the disease. With the help of an involved cancer patient, CanSurmount was then developed into a pilot program at a Denver hospital where it caught the interest of cancer patients and medical professionals.

It was from that starting point that CanSurmount has evolved into a "therapeutic community" made up of cancer patients, families, and medical professionals. There are now 17 CanSurmount chapters in eleven communities in Colorado, with more in the planning stages. CanSurmount is governed by a 31 member volunteer Advisory Board which functions under the supervision of the American Cancer Society Service and Rehabilitation Committee. Each CanSurmount chapter is directed by a coordinator who is responsible for the day-to-day activities of the group, handling patient referrals from physicians, assigning volunteers to visit the patient, and maintaining records of the visit, organizing monthly volunteer meetings, helping to screen and train new volunteers, acting as liaison between the hospital staff and volunteers, conducting in-services and support and encouraging the volunteers. From the few volunteers who originally launched the program there are now 150 involved in Colorado. The youngest is 20\* and the oldest is 85. The majority of these are women. Dr. Bramley recently stated that "Because CanSurmount volunteers have cancer themselves, they are in a position to better understand and cope with cancer."

"Trained volunteers visit with patients, with visits varying from casual conversation to meaningful support for the patient," Dr. Bramley added. According to Dr. Paul Hamilton, the program founder, these visits provide a link in communications between the health professional and the patient. As a

CanSurmount volunteer recently said, "CanSurmount puts its members on a very 'equal' level with the doctor who founded it - who happens to be doctor to many of us. It is a very delightful experience to have a real friendship, 'working relationship' (i.e., accepting invitations to speak on panels, be videotaped, etc.) with your doctor. "I'm sure the other doctors who support CanSurmount can have a good relationship with their patients who are members, for members often report to doctors on problems they encounter with hospitalized patients. It is very dignifying to the member, who is also a patient, to have this added access, or audience, with his doctor.

"When I first arrived and knew it was not out of the question for things to go badly for me, for me to end up in a hospital bed, I thought 'now, here, I could die.' I had come from a big hospital with extremely negative doctors and one of the reasons I fled them was that I was loath to die in front of them. Fulfill their prophecies! Somehow, when you are so loved by a group who knows what cancer is all about, you let your defenses down and you don't have to stay alive out of spite. You can relax and love back."

\*Actually, the youngest is a 2-year-old with rhabdomyosarcoma, who accompanies his leukemic grandmother on her visits.

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## new officers

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### NORTHWEST COLORADO MEDICAL SOCIETY

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Michael D. Hostetler, MD  
P.O. Box 9058  
Steamboat Springs, Colorado 80477  
879-3327

#### SECRETARY/TREASURER

Richard T. Batts, MD  
Routt Memorial Hospital  
Steamboat Springs, Colorado 80477  
879-1322

# The Case For The HMOs

Recent developments in the efforts to provide low-cost health insurance have caused many physicians and hospitals to create health maintenance organizations (HMOs) in an attempt to control the increasing costs of medical attention, deliver quality care and generate consumer satisfaction. Many are successful; some are not.

## The Past: The End of the ChoiceCare Experience.

In January, 1980, *Colorado Medicine* reported on the demise of "ChoiceCare," an HMO/IPA which operated for approximately 5 years in Northern Colorado. The independent professional association aspect of ChoiceCare was the Physician's Service Corporation, based in Fort Collins but including a majority of physicians practicing in Larimer and Weld counties. On December 19, 1979, the Colorado Insurance Commission ordered ChoiceCare to be put into a conservatorship. ChoiceCare ceased operations on December 31.

At the time of the *Colorado Medicine* report, an effort was made to gather interested and concerned parties to the matter, to decide whether ChoiceCare should be continued in receivership, or should be liquidated. That meeting was not held until late January. On January 23, 1980, a court order was obtained to place ChoiceCare into receivership, for the purposes of liquidation.

Colorado Insurance Commissioner J. Richard Barnes was authorized to appoint a Special Deputy Commissioner as receiver. Commissioner Barnes attempted to find a qualified person in Fort Collins, in order to prevent additional commuting expense from Denver. On February 22, 1980, the court in Fort Collins recognized Mr. Richard Sherman as the ChoiceCare Receiver. Mr. Sherman is a Fort Collins resident, who served as comptroller for the Silver States Savings & Loan Association for five years, and held a similar position with Midland Federal Savings & Loan Association for fifteen years, four of which were spent as Manager of Operations for Midland in Fort Collins. Mr. Sherman is now the Special Deputy for the Receiver of ChoiceCare.

Liquidation preparation has been proceeding. As of March 1, ChoiceCare employees were reduced from 60 to 9; the lease on the Fort Collins offices has been terminated, and offices are now rented on a month-to-month occupancy; the computer services have been terminated, and the owners of the computer service have been instructed to remove the computer from the premises (the data which was on the computer was limited, chiefly, to claims information, and reportedly was not up to date; there-

fore, the Insurance Commissioner felt the information was of little help. The Commissioner instructed that ChoiceCare's general ledger be reconstructed, effective January 1, 1980). As of March 1, the Insurance Commission has reported to *Colorado Medicine* that within 60 days the Commission will have further cut expenses, and will have martialed all of the ChoiceCare assets for liquidation.

The ChoiceCare receiver told *Colorado Medicine* that if as many as 25 physicians had been willing to remain with ChoiceCare in December, 1979, the U.S. Department of Health, Education and Welfare was ready to underwrite the continuation of the HMO, giving the plan the necessary "cash booster" required to place ChoiceCare on a sound footing. The amount advanced by HEW would, however, have been a loan, which the physicians were unwilling to accept. Even though the receiver is now ready to go to the court to ask for authority to make the first distribution of funds in the liquidation, HEW still holds a total lien against ChoiceCare assets, due to its owing \$700,000 to HEW.

Physicians, according to the Insurance Commissioner, are still liable, in the eyes of the court, for practice under the terms of the contract which they held with ChoiceCare until the receivership was declared by the court. The Insurance Commissioner's office revealed that some of the physician members of Physician's Service Corporation, following the decision to cease operations of their service to ChoiceCare in December, immediately started charging their former ChoiceCare patients 100 per cent of the usual and customary fees.

The ChoiceCare receiver said the area hospitals also made this charge, which is in violation of the service contract. Some of the participating physicians, however, have indicated that they would file suit to collect all or a portion of fees owed them for service previously rendered ChoiceCare patients. According to the receiver, all but the Medicare supplemental insurance policyholders have been re-insured under some other program, but with no coverage for pre-existing conditions.

## The Future: How will the HMO/IPA fare in coming months?

In Colorado, Comprefcare is probably the most logical focal point for considering the future of the HMO.

Comprefcare was formed in 1973 by the staff of Mercy Hospital. Within two years it had grown large enough to warrant its movement to its own building, housing offices and clinics. Physicians,



other than the Mercy Hospital staff, were allowed to join the HMO, thus giving birth to the Columbine Medical Group. Since its federal qualification as an HMO in 1976, Comprecare has become the fastest-growing such organization in the Denver area, and has become a trend setter in the competitive insurance field.

Why has Comprecare such a widening consumer interest? The reasons are bedded in the accessibility factor. Comprecare is made up of doctors on the staffs of hospitals throughout the Metro Denver area; thus, convenience. Patients are also able to retain their family doctor, saving the problem of finding another doctor to accommodate their health plan's requirements. These two factors are "extras" to the HMO's regular services, which include free office visits to the physician, periodic checkups, diagnostic and other services, all covered fully by the Comprecare premium. Services, such as house-calls and out-patient care, are covered by a co-payment not exceeding \$20.00 each visit. These are all items which the traditional health insurance does not cover. Comprecare is definitely a "pre-paid" form of insurance.

How does this pre-paid health insurance affect physician and hospital fees? Physicians negotiate a fee scale, annually. They are generally paid 85 per cent of the usual and customary fee, while the remaining 15 per cent is placed in a risk pool to cover excess expenses in some cases. If not used, the risk pool funds are to be returned to the physician.

Hospital rates are made more affordable by a pre-certification of elective admission for the patient. If a physician should fail to apply for a pre-certification, his standing in the Columbine Medical Group could be in jeopardy.

Many physicians join the HMO annually because it offers established practices a chance to retain patients who are already covered by the HMO. For physicians who are trying to build a practice, the Comprecare plan offers new patients as an incentive.

Comprecare has had financial difficulties in the past few years, despite federal loans. The plan reportedly has been short in excess of \$500,000 per year. Factors contributing to this lack of adequate cash flow have been 1) heavy use of physician and hospital services by new members (particularly during their first year of membership); 2) reforming by the now-defunct Colorado Hospital Commission of hospital cost control methods, which also created a money shortage for Comprecare, and; 3) federal regulations, governing premium levels to be evaluated by the community's ability to pay, which had a serious effect on Comprecare's total cash or reserve position.

What of the future of Comprecare? If the program can resolve its financial dilemma, and continues to serve the community with low-cost medical treat-

ment and health care, Comprecare will become a positive incentive for formation of new, competitive HMO programs. It will, thereby, be serving the community, the physicians, and the hospitals effectively and inexpensively.

Colorado Insurance Commissioner J. Richard Barnes told *Colorado Medicine* that his offices are closely monitoring the Comprecare operations, as well as all other HMOs in the state, to help prevent the situation which developed in and, later, consumed ChoiceCare. Mr. Barnes points out, too, that participating physicians do have a continuing risk element, even if an HMO fails, but he adds that his office still looks upon the HMO as a viable means of cost containment, with worthwhile results for all parties, if given to wise and effective management of the program.

Bill Pierson  
Executive Editor



"Tammie" is witness to the presentation, on her behalf, of a check for \$2,000.00 payable to the Hall of Life, Colorado Health Education and Information Center, Denver. The check is presented by Ray G. Witham, M.D., President of the Colorado Medical Society, and member of the Colorado Medical Foundation Trust. The Foundation Trust made gifts to four health-oriented organizations in Colorado in early 1980. Receiving the check for the Hall of Life are Mary Baca (center), Vice President, and Leo J. Nolan, M.D., President, Hall of Life. "Tammie," in the background, is the Transparent Anatomical Mannequin (TAM) which has just been put into place and in full operation, the first of many such health education exhibits which are planned in the Hall of Life, located in the Blue Cross Building, 700 Broadway, Denver. (See story about TAM in "At Press Time" section of this edition.)

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## staff profile

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Introducing Lorraine Koehn (pronounced: CANE), Staff Assistant, Government Affairs Division, Colorado Medical Society. If it could be said that matters concerning government affairs and medicine could be pleasurable, that dealing with the day-to-day problems of lobbying, of turning out legislative information, of answering all the questions which would normally be directed to the lobbyist, but who is not available because she is lobbying, then it can be said that Lorraine makes these matters pleasurable because of her interest and attitude. Lorraine does a yeoman's job of acting as the go-between from the legislature to the Society members and staff.



Lorraine is originally from Pierre, South Dakota, where she worked for 2 years with the S.D. Department of Health. She had a short tour as legal secret-

ary to the South Dakota State Attorney before going to six years as Administrative Assistant for the Dean of Student Affairs at the South Dakota School of Medicine. Lorraine did a stint as Financial Aid Director at the school, as well.

It was in May of 1978 that Lorraine's husband, Elmer, suffered a heart attack, and the family decided it was time for them to slow their pace and start getting more out of life instead of putting so much into living. Elmer had been manager of a savings and loan office in Vermillion, S.D., when he was stricken. The Koehns moved to Denver with the intention of settling later in a small, mountain community in Colorado. However, after Lorraine started with the Colorado Medical Society they found they liked Denver so much they're planning on staying. During all that busy life, the Koehns have raised three daughters, who are now grown and all leaving home during the next few weeks. Jo is a Social Worker employed at Children's Hospital; Joni will be studying theatre in college at Nagoya, Japan; Janet will be married in October. Lorraine said she thought she would never have another position she enjoyed as much as her work at the South Dakota School of Medicine, but she says she's found it at CMS. Lorraine has been with CMS a year and a half, and looks forward to many more, because Lorraine Koehn has become an integral part of the Government Affairs Division.

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## NEW RADIO PROGRAM SERIES BEGINS, FEATURING PHYSICIANS.

Dear Colleague:

Your Colorado Medical Society, Department of Communications, is developing opportunities to work with local radio and television stations to produce interview programs on medical topics. To insure professional medical input into this public health education, your participation is needed.

If you would be willing to represent your component medical society by discussing one or more of the topics listed (on an interview format radio program) please indicate by making a check (✓) opposite the topic(s) you select. Return this form to Communications Department, Colorado Medical Society, 1601 E. 19th, Denver, Colo. 80218. The program in which you participate will be credited, on the air, to your component society.

We are being assisted in this program by the Professional Communications Department of Burroughs Wellcome Company. B - W representatives will be doing the tape-recorded interviews for the programs. THE INTERVIEW WILL BE DONE IN YOUR OFFICE...AT YOUR CONVENIENCE. Burroughs Wellcome Co. is never mentioned in the program. Again..... your component medical society receives air credit for the programs. The order in which topics will be discussed will depend on the timeliness of the information, relative to community interests and needs, and the availability of the physician to be interviewed. The programs will be distributed, state-wide, to a number of participating radio stations. Your area, wherever you practice, will be included.

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For further information, contact: Department of Communications, CMS

Denver: 861-1221, Extension 249

Outside Denver: 1-800-332-4150 (toll free)

## MEDICAID UPDATE

On March 6, 1980, physician representatives met with the Colorado Department of Social Services and its fiscal intermediary, Colorado Blue Cross and Blue Shield, and negotiated the following general policy breakthrough:

FIRST: That the level of reimbursement for physicians under the Medicaid program must be raised to the maximum allowable levels if patient access to care and physician participation are to be increased. It is further understood that the groups above will work in a joint fashion to achieve this - their number one priority. A target date for the submission of a budget request which will so raise reimbursement levels is January 1981.

SECOND: That a change in the method of reimbursement for obstetric care will soon be present. In the past, a trimester, or piecemeal, system was used. Now, the Department of Social Services is willing to move to "global" reimbursement. Guidance from the Colorado OB/GYN Society and the Colorado Academy of Family Practice will be accepted by the Department of Social Services on this matter.

The physicians present who accomplished these negotiated stances were:

Noel Sankey, M.D.; William Curtis, M.D.; Gatewood Milligan, M.D.; Richard Penfold, M.D.; John Chatfield, M.D.; F. I. Nicks, M.D.; W. L. Bennett, M.D.; Harvey Phelps, M.D.; Ed Rhodes, M.D.; James Syner, M.D.; Nate Clifford, M.D.; Arthur Klemme, M.D.; and S. Jack Locke, M.D.

These physicians are members of a standing committee which now meets regularly to improve the Medicaid system.



A small but effective group attended the 3-hour workshop on Society communications Saturday, March 1, at Writer's Manor. (L to R) Bill Pierson, CMS Director of Communications, listens as Joe McGowan, Bureau Chief of Associated Press, Denver, explains the workings of news gathering and dissemination. Bob Hahn, Denver Medical Society Director of Communications, another panelist, also listens closely. In attendance were 3 former CMS Presidents, 5 CMS Board members, 1 AMA Alternate Delegate, the Colorado and Denver Medical Society Auxiliary Presidents, and several other persons from various components.





Colorado Medical Society Lobbyist Carol Tempest was the guest speaker for the inaugural "Colorado Close Up" program, held in Denver during February. Colorado Close-Up is an off-shoot of the Close-Up Foundation based in Washington, D.C., bringing highschool junior and senior students to the nation's capitol for a solid week of "hands-on" experience in the nation's government. Colorado Close-Up has, this year commenced a program wherein highschool students from all parts of Colorado come to Denver to study state government for 2½ days, coupled with workshops, seminars and discussions led by the legislators and government officials.

In their first evening in Denver the students, approximately 50, were given an introduction to the typical press and news coverage of the state affairs, then were indoctrinated into the total legislative process by lobbyist, Carol Tempest, herself a former Colorado state legislator. Carol was greeted by a group of young people who are genuinely interested in the processes (Carol added even she didn't realize the young

people of highschool age were quite so sharp). Bill Pierson of the CMS Department of Communications, himself a former statehouse reporter for 23 years, conducted an afternoon panel discussion. Participants were Richard Buholz, Broadcast Editor, Associated Press, and Ed Sardella, Reporter and Anchorman on KBTU, Channel 9 in Denver. The three panelists were challenged repeatedly, but their answers were logical, concise and well accepted.

The Colorado Close-Up program was highly effective, students went back to their respective areas of the state with renewed interest in the political process, hopefully to take part in local precinct caucuses.



James J. Mongan, M.D., Associate Director for Health and Human Resources of the Domestic Policy Staff at the White House. Mongan addressed The Colorado Foundation for Medical Care at The Winter Clinics of The Colorado Medical Society in Denver on February 29, 1980.



**HEALTH POWER LOOKS GOOD** Barbara Brown of the Denver Medical Society Auxiliary, Immediate Past President, models one of the Colorado Auxiliary "Health Power" T-Shirts for the group of Auxiliaries at a Winter Clinics luncheon and style-show, Friday, February 29th, at Writer's Manor. March is "HEALTH POWER MONTH" in Colorado.

## MAYOR McNICHOLS PROCLAIMS

Below, Denver Mayor William McNichols has proclaimed the month of March, 1980, as "HEALTH POWER MONTH" for the entire city. Shown with the Mayor in his chambers as he signed the proclamation are (l to r) Mrs. Paul G. (Betsy) Becker, Colorado Medical Society Auxiliary President, Mrs. Charles W. (Barbara) Brown, Past President, Denver Medical Society Auxiliary, Mrs. Theodore R. (Roberta) Sadler, Jr., President-elect, Denver Medical Society Auxiliary, and Mrs. William (Bunkie) Inkret, Jr., Denver Medical Society Auxiliary President.



Above, Denver Mayor Bill McNichols tries out the HEALTH POWER T-shirt which was presented to him following his proclamation of March, 1980, as HEALTH POWER MONTH for the City of Denver. (l to r) Roberta Sadler, DMS Auxiliary President-elect, Betsy Becker, CMS Auxiliary President, Mayor McNichols, "Bunkie" Inkret, DMS Auxiliary President, and Barbara Brown, DMS Auxiliary Past-President.

## HEALTH POWER MONTH

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## The Library: A Crucial Center

The degree to which the Colorado medical profession is centered on the Denver Medical Society Library is beginning to be realized by an increasingly broad spectrum of the CMS membership. Since being founded in 1893, the Library has been crucial to the practice of medicine in Colorado.

The Library has quarters in the building at 1601 East 19th Avenue in Denver which it owns, and shares with the Colorado Medical Society, the Denver Medical Society, and the Colorado Foundation for Medical Care. The bright natural light which flows into the library from the south increases the inviting atmosphere established by the Librarians in order to encourage sober study and thought as well as relaxation and quiet-voiced conversation.

The Library staff of three, comprising Mary De Mund, Library Director; Martha Burroughs, Reference Librarian; and Vanessa Stephens, Library Assistant, is on hand to serve and give individual care to the concerns of the doctors who come for information.

The Library is interested in the past, the present, and the future.

The walls of the hallway adjacent to the Library reflect the past with its relics of 19th century medicine, including a mortar and pestle dated 1639, presented in 1933 by Miss Helen Bonfils, and a can of Denver Mud, according to its descriptive essay, an assurance of curing pneumonia, preventing the need for tonsilectomies, halting ulcers, and killing "the grippe."

In the Library itself are three cases of vintage eyeglasses which stress the importance of the past.

But it is as a service center for medical information that the Library functions as a positive force in Colorado.

The aim of the librarians is to assist the busy practitioner with comprehensive searches for needed information, to get it done quickly, and to develop both on-line and manual search methods of attainment.

Most Denver area hospitals have libraries of some description, but except for Denison Library at the University of Colorado Health Sciences Center and the Fitzsimons Army Medical Center Library none have the depth in collections of the DMS Library.

Recently the Library received a request for information to assist the case of a welder assumed to be suffering from zinc poisoning. There was a question whether the zinc or cadmium was the culprit. This case in La Junta was obscure, and the doctor called the DMS Library as the logical source for comprehensive information.

Manual searches are made by reference to the Indexus Medicus which categorizes material by subject, providing year, volume, and pages of all relevant articles in international medical publications. Until last year most searches were manual, but then the Library became a MEDLINE center.

This system is directly linked to the National Library of Medicine at Bethesda, Maryland for a Computerized Literature Retrieval Service, which provides the Library with a major data base.

A terminal is located in the Library offices, and within minutes it can generally provide needed information on case histories of obscure or little understood medical problems.

The librarians use their own discretion in deciding what recommendation to use in gathering information. There is a slight charge for MEDLINE searches.

To provide doctors with all the materials available both on-line and manual searches may be employed.

To give doctors an understanding of the MEDLINE procedure, Martha Burroughs, the Reference Librarian, gives demonstrations on a regular basis, and she will present a demonstration during the Winter Clinics.

The Library seeks to reach as much of the membership as possible, and to provide, with individual caring and concern, that service which is quick, reliable, and of quality.

Allen Young  
Assistant Editor

## Certificate of Service and Robins Award

The deadline for receipt of nominations for the Colorado Medical Society's *Certificate of Service Award* and the Annual *Robins Award* is June 15, 1980.

The Certificate of Service is the highest award given by the Medical Society to a physician "for outstanding contribution to the Constitutional purposes of the Society."

The purpose of the Robins Award is to honor a physician in our state "for outstanding COMMUNITY SERVICE."

Send nominations to the Confidential Awards Committee, 1601 E. 19th Ave., Denver 80218. These awards will be presented during the Colorado Medical Society's Annual Session, September 24-27, 1980, at The Broadmoor.

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## the lobby

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The Colorado Hospital Commission has expired. It was a short life filled with anxiety, distrust, and vast amounts of paper. And perhaps it was the personalities of some of the original commissioners that dealt the real death blow. For whatever reason, there will not be a commission on March 1st.

The legislation which created the commission was intended to create a Colorado cost containment mechanism which would oppose control by proposed federal mandates. The weakest part of the law was the failure to provide enough lead-in time for the commission to hire a director and get itself organized before beginning to review hospital budgets. It got off to a disorganized start and adopted rules that appeared not to comply with the intent of the legislators, especially in terms of payment differentials to third-party payors.

Other rules omitted growth and development funds for hospitals' future plans, thus alarming hospital trustees whose long-range planning committees had conscientiously blue-printed their hospital's futures. In some cases, financial reserves were transferred to the operating budgets.

But the real culprits were paper and personalities. Mounds of paperwork were involved in each review and often were repeated when a budget was turned down. This was difficult enough for large hospitals but an enormous problem for small ones. Add an adversarial nature to the hearings, and you see what happened in the minds of hospital administrators.

A few administrators honestly feel that hospital costs will continue to rise for many reasons, and that a commission does serve a valuable function. Also they continue to feel that the threat of a federal cost containment law is ever present and that some kind of state commission is far superior.

Senator Strickland (R), Westminster, chaired the Senate committee in which the bill to continue the Colorado Hospital Commission was debated. Senator Woodard (R), Ft. Collins, was the bill's sponsor and was given 25 minutes to use in any way he wished. His speakers were long-winded, and as a result several of his announced witnesses were not heard. The Colorado Hospital Association was given 25 minutes to speak against the bill and completed its very organized testimony in 23 minutes. With direction from the CMS Council on Legislation, Dr. Mason Howard testified admirably in the latter group. In about one hour, the bill was killed on a 6 to 2 vote.

A tribute should be given to the three commissioners appointed by Governor Lamm last summer. Philip Milstein, Mrs. Frances (Salty) Welborn, and Craig Barnes did everything possible to abbreviate the paper forms, put a smile on the commission, and write a new bill that could win approval in this year's legislature. They failed but not from lack of trying - they started from too far behind.

So now the hospitals of Colorado have the awesome opportunity and responsibility to keep the increase in costs down on a voluntary basis. Physicians will no doubt be asked to play a role.

*Carol Tempest*

## CMS Questions New Collision Regulations

Effective January 16, 1980, the Colorado Department of Health adopted regulations relating to deaths from motor vehicle and aircraft collisions. At base, the regulations govern the obtaining of blood and urine samples of pilots, drivers or pedestrians dying within four hours after a collision involving vehicles or aircraft.

The operative section gives coroners, law enforcement officers or "attending physicians at the time of death" the "authority and responsibility" to direct that blood and urine samples be taken. The Colorado Medical Society has questions about the regulations. What, for instance, is an "attending physician?" The condign definition would be a physician present at death. But nothing in the regulations defines "attending."

The regulations were adopted as emergency regulations, without following normal notice and hearing patterns. The CMS will pursue the matter through other avenues.

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## new members

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**Pueblo County Medical Society:** Donald F. Benton, Luis C. Cabiling, Jr., Arthur H. Halprin, Stuart K. Olvey.

**Weld County Medical Society:** Jack L. Berry, Robert S. Pace.

**Arapahoe County Medical Society:** Steven T. Charles, Joshua R. Pushkin.

**Fremont County Medical Society:** Donald F. Page, Charles H. Harris.

**Lake County Medical Society:** Sanders S. Ergas, Charles A. Blakely.

**Chaffee County Medical Society:** David M. Arnett.



## Blood Test Not a Marriage License Need

By action of the 52nd Colorado General Assembly, the blood test for syphilis no longer is required as a preliminary to a marriage license. Assurance by the Colorado Department of Health that the syphilis rate was low among heterosexuals was the principal determining factor in affecting the course of legislation.

Women under 45 years of age who do apply for marriage licenses will have to undergo tests for rubella and Rh blood type, two birth defect-related variables which can better be controlled when the negative state is detected.

Older women and post-hysterectomy women are to be exempted from such tests.

These modifications and revisions were supported by the Council on Public Health of the Colorado Medical Society in 1977, and were supported as well by the National Foundation/March of Dimes.

### Blount Receives Cardiology Honor

S. Gilbert Blount, MD, Denver, was named by the American College of Cardiology to receive the 1980 Gifted Teacher Award at the 29th Annual Session of the College in March at Houston, Texas.

## Council on Legislation

The Council on Legislation has met on a weekly basis since the beginning of the 1980 legislative session. A great deal of effort has been spent in reviewing SB 105 Concerning the Nurse Practice Act. The major concern of Council members centered around the word "supervision" - it was the consensus of opinion that CMS should make every effort to assure that this word remains in the bill.

KeyMen to the Senate HEWI committee were alerted and asked to contact their legislators and convey to them the need for physician supervision which need not be on-site, over-the-shoulder supervision, but assuring the direction and coordination necessary for the patient's well-being.

Plans for the 1980 Legislative Seminar to be held in Vail on May 30, 31 and June 1 are being formulated (See announcement elsewhere in this issue).

The Council urges CMS members to call the Legislative Hotline for the latest news on health-related legislation (832-9527).

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# Non-cardiogenic pulmonary edema from accidental hypothermia

*Macabre experiments by Nazi researchers in the 1940's with induced hypothermia on involuntary subjects, as well as more defensible studies of hypothermia in animals, and with controlled hypothermia in patients, have led to the straightforward conclusion that the end-organ failure in accidental hypothermia is the heart, with the terminal event being ventricular fibrillation. This conclusion has been partly offset by the notation of signs of pulmonary edema in victims of outdoor hypothermia even at lower altitudes. In the course of a large study of "urban" accidental hypothermia victims reported elsewhere by the author, one case was encountered which permitted objective confirmation of the phenomenon of non-cardiogenic pulmonary edema in a patient with severe hypothermia.*

## CASE REPORT

CP was a 77-year-old white female who lived by herself, who was brought to the Denver General emergency room in early September in severe respiratory distress. Since the patient was oriented to one person only, the only known history was that she had been found in a tub of cold water at her home but not in a position suggesting possible submersion.

Because of her audible rales up to both upper lung fields, frothy sputum and cyanosis, she was treated as a case of acute pulmonary edema with diuretics, digitalis, and a small dose of morphine sulfate. Initial blood pressure was 120 systolic, pulse 124, and respiratory rate 30. Immediate arterial blood gas values (on room air) were pH 7.40, PO<sub>2</sub> 36 and PCO<sub>2</sub> 37.

She was admitted to the intensive care unit for continuation of her aggressive therapy. There, while her skin had been already noted as being cool, her rectal temperature was first recorded as 27.0 degrees C. (80.6 degrees F.). Thereafter, in addition to continued efforts for cardiorespiratory stabilization, she was treated with warmed blankets and then a "K-thermia" blanket. Although she had no known cardiac disease and her EKG showed no evidence of a myocardial infarction (nor of J-waves), a Swan-Ganz catheter was placed to monitor response to fluid therapy and the use of Dopamine. The pulmonary artery pressure was found to be 32/10 mm. and the wedge pressure only 4 mm.

The patient's condition and in particular her arterial oxygenation showed rapid improvement that seemed to match her quick return within 3 hours to a core temperature of 37.0 degrees. Her subsequent course was uneventful with no evidence of cardiac failure.

Further history determined that the patient had evidence of depression, and was on Valium and Antivert and had recently been put on an oral hypoglycemic agent (lab tests did not confirm any hypoglycemia). While there was some question of a past suicide attempt, the patient only stated that she had felt "dizzy" so she took two Antivert and chose

## A Case Report

Kevin M. O'Keeffe, MD, Greeley, Colorado\*

to lay down in a tub of shallow, chilled water and then fell asleep! During the rest of her stay there were no complications and the patient was discharged on the fourth hospital day in good condition.

## Discussion

While cases of hypothermia are probably even less rare than other more often cited environmental entities, such as snakebite and certainly, of lightning victims, it is difficult for one center to collect a large series, or to effectively monitor each case closely. The author was able due to the unique catchment factors of Denver General Hospital to encounter a fairly large number of cases during his stay there.<sup>1</sup> It is recognized that this was, in itself, a selected population, particularly with regard to attempted investigation of the terminal event in accidental hypothermia victims, as only one out of seven deaths occurred due to hypothermia alone. This death did occur through the mode of cardiac dysrhythmia but only after inadvertent patient manipulation. Two other patients also were documented to go into cardiac arrest (ventricular fibrillation) after therapeutic manipulation. As noted in the author's study, other recent reports of ventricular fibrillation in four hypothermic patients disclosed that they similarly occurred after intubation or other invasive manipulation. Unfortunately, the patients evaluated in the author's study included only those near death or who died after contact, with no provision for pathologic post-mortem study of victims of probable hypothermia in the urban area of the study.

In general, this general experience seems to support the conviction already held that the heart is the organ at risk in hypothermia. This was crudely determined by the heinous reports of the Nazi doctors in their World War II records. However, animal experimentation and the experience with controlled hypothermia principally in cardiac surgery largely confirmed this thesis, as reported classically by Swan.<sup>2</sup>

Nevertheless, in reviewing available literature on true accidental hypothermia, the author came across mention by Lathrop in his monograph of the finding of pulmonary edema in fatal cases of hypothermia in outdoorsmen, with the specific notation that an Oregon pathologist "found evidence of pulmonary hemorrhage in each of the ten fatal cases of accidental hypothermia that he reviewed."<sup>3</sup> This report was



accompanied by the author's recognition that true accidental hypothermia victims are not manipulated by therapeutic attempts, nor are they subject to cardiac sensitizing drugs such as some of the anesthetics used in cardiac surgery.

It was only by the good fortune of the presentation of CP and her subsequent documentation that any challenge of the cardiac terminal event thesis was raised. There were no other factors feasible in her case as a substantial etiology of her acute pulmonary edema other than the severe hypothermia and specifically no likely role of cardiac disease in view of the catheterization results.

Now, cardiogenic pulmonary edema is an interesting non-specific entity having been reported from

several etiologies, most notably drugs, particularly narcotics,<sup>4</sup> and high altitude sickness.<sup>5</sup> The pathophysiology involved is uncertain but some animal experimentation has suggested that it is mediated by a cranial-pulmonary reflex with pulmonary hypertension triggered by cerebral hypoxia, although it may represent no more than a multifaceted stress response.

In any event, it is hoped that other similar cases will be encountered and studied, as well as increase use of post-mortem examination of the victims of hypothermia.●

\* The author has since relocated to practice as an emergency physician at Virginia Mason Hospital, Seattle, Washington.

#### REFERENCES

- <sup>1</sup> O'Keeffe, K.: Accidental Hypothermia: A Review of 62 Cases, *JACEP* 6:11 pp 491-495, November 1977.
- <sup>2</sup> Lathrop, T.: Hypothermia: Killer of the Unprepared, *Mazamas*, 1975 (quote from p 12).
- <sup>3</sup> Swan, H.: *The Use of Hypothermia in Cardiac Surgery in the Physiology of Induced Hypothermia*, Publication 451, Government Printing Office, 1956.
- <sup>4</sup> Duberstein, J., and Kaufman, D.: A Clinical Study of an Epidemic of Heroin Intoxication and Heroin Induced Pulmonary Edema, *Am J Med* 51:704-715, December 1971.
- <sup>5</sup> Scroggin, C.H., et al, High Altitude Pulmonary Edema in the Children and Young Adults of Leadville, Colorado, *N Engl J Med* 297:1269, December 8, 1977.

## A Perspective Look at Radiation and Human Health

The first of this series appeared in the February issue and discussed the origin of radiation standards. Several authors have been asked to contribute in the remaining articles in this series. The next issue will address how the radiation standards are applied, i.e. the control and monitoring of personnel exposure. Subsequent articles will discuss the radiation health effects seen in animal and human studies, environmental radiation perspectives, and what human epidemiological studies have shown us about radiation effects. The concluding article of the series will deal very specifically with a realistic look at radiation and the Rocky Flats Plant. It is hoped that this series will be both interesting and informative to the readers.

R.W. Bistline, PhD.

# Meniscectomy through the arthroscope

Kenneth J. Cavanaugh, MD, Longmont, Colorado

*Arthroscope surgery is a new technic whereby the meniscus is removed through two to three stab wounds. This can be done as an outpatient procedure or with one day hospitalization. Procedure is more economical, with faster rehabilitation than an arthrotomy.*

The arthroscope was pioneered by Dr. Masaki Watanabe in Japan in the 1960's. This technic was introduced in North America by Dr. Robert Jackson of Canada shortly thereafter. Dr. Lanny Johnson, Dr. Robert Metcalf and Dr. Richard O'Connor developed the technic of surgery through the arthroscope in the past few years. This report is a review of fifty consecutive cases in the past one and one-half years with followup of four to twenty months.

## Material and Method

Surgery was performed on fifty individuals from whom fifty-four menisci were removed, of which two had both lateral and medial meniscus tears; two had bilateral tears. The individuals ranged in age from 16 to 80 years with a mean of 40. There were 41 males and 9 females; 28 right knees and 22 left knees. Involved in this study were 39 medial and 34 lateral menisci. There were 27 parrot beak tears; 16 bucket handle tears; 5 degenerative tears; and 6 horizontal tears.

## Technic

All surgery was performed in the operating room under sterile conditions with a general, spinal or local anesthesia. The operative technic was with a Wolf 5.6 mm. or 2.7 mm. arthroscope removing the meniscus through separate stab wounds under direct vision. Partial meniscectomies were done in all cases. The duration of surgery ranged from one-half hour to two and one-half hours with an average of one hour and fifteen minutes.

## Results

Of the fifty patients operated on, two patients had second surgeries after recurrent injuries, and these will be discussed later. All patients operated on, with the exception of four, were discharged on the day after surgery. Of the four kept in the hospital longer, three had other surgeries done and the fourth was delayed because of pain and difficulty using crutches. At the present time most patients are done as outpatients. Of the fifty patients, all were returned to work within four weeks. Twenty of the fifty patients returned to school or work within three days. The

return to work schedule was as follows:

- 36 patients within the first week
- 4 patients in the second week
- 8 patients in the third week
- 2 patients in the fourth week

These patients could return to work despite mild pain and swelling. In judging when the patient returned to full activity, that is returning to full normal activity (housework, running, hiking, walking, sports), the breakdown is as follows:

- 13 by first week
- 17 by second week
- 4 by third week
- 10 by fourth week

Of those whose return to full activity was longer than four weeks, one patient returned to work in two weeks but did not have full activity for approximately eight weeks because of muscle pain in the quadriceps area. An eighty year old patient with severe arthritis had relief of a catch and clicking, and returned to her housework with considerable pain. She needed a total knee arthroplasty after one year. Another patient returned to teaching tennis in one week and light playing in two weeks but could not play in a tournament in eight weeks because of pain where the arthroscope had been inserted. Another patient was delayed full activity because of a weak quadriceps muscle and another had effusion at six weeks which resolved spontaneously. One patient who had secondary surgery was delayed eight weeks before returning to full activity, however, the knee gave her no difficulty by the third week.

In trying to determine statistically what factors were involved in the return to work and full activity, I graded the amount of arthritis that was present in each knee. There was no correlation between the amount of arthritis present and the time that these patients could return to work. There was a tendency for the patients to return to work in one week under forty years of age but this was not statistically significant.

## Comments and Discussion

Arthroscope surgery is better tolerated by patients with a faster rehabilitation than an arthrotomy. It is also more economical for the patient and the employer. Patients were at one time admitted the day of surgery (at the time of this study) but now the majority are done as outpatients. Over seventy per cent of the patients returned to work in one week.



Post-operative, most of the patients had a mild effusion the first week but this did not interfere with their ability to return to work. In this study two patients had mild effusion for four weeks and six weeks respectively which cleared spontaneously and they returned to work within two weeks. Also, it was found two patients had severe quadriceps atrophy, even though they returned to work within two weeks. There were two cases of superficial thrombophlebitis which developed after hospitalization and both cases cleared with proper treatment. Another patient developed a small cyst where the arthroscope was entered into the knee, which is still present today but asymptomatic after one and one-half years. A patient had periodic pain with physical activity where the scope was entered; another patient a synovial cyst was present medially, however, after a partial medial meniscectomy this disappeared.

Two patients had re-injury. One patient was a twenty-eight year old who stepped in a hole while running, five months after his initial injury and tore the posterior horn of the medial meniscus. Initially there was a parrot beak tear of the medial side of the meniscus. This patient was operated on, and is presently doing well. The other patient was a seventeen year old who had a posterior medial parrot beak tear and a two year history of pain. While playing basketball approximately three months after surgery, he began having pain in the anterior portion with a click anteriorly. Under a local anesthesia a new parrot beak tear was found at the anterior horn of the meniscus and this was removed. Presently, this patient is doing well. Where the previous partial meniscectomies were done on these two patients, there was no evidence of re-tear or arthritis.

#### *Arthrotomy vs. Arthroscope Surgery*

In review of arthrotomy cases where a meniscectomy was done, hospitalization ranged from two to seven days with an average of 4.2 days; whereas with arthroscope surgery it was one to two days with an average of 1.2 days of hospitalization. Patients having an arthrotomy returned to work in fourteen to fifty-seven days with an average of thirty-two days, whereas with arthroscope surgery the return to work was three to thirty days with seventy per cent returning to work in one week and one hundred per cent in four weeks.

#### *Summary*

This study is of fifty consecutive cases in which seventy per cent of these patients returned to work within one week and essentially all by four weeks. Thirty of the fifty patients returned to full activity by two weeks and forty-four of the fifty patients by four weeks. No statistical correlation of age, type, location or tear, or amount of arthritis could be found to determine when a patient could return to work or full activity. Arthroscope surgery has a faster rehabilitation than arthrotomy and is much more economical for the patient and employer. In the future, I feel arthroscope surgery will be a standard type procedure for removing torn menisci. ●

## book corner

### PSYCHOLOGY

**Death, The Final Stage of Growth:** Elizabeth Kubler-Ross, ed. Englewood Cliffs, N.J., Prentice-Hall, 1975. 175 p. \$9.95.

**To Live Until We Say Good-Bye:** Elizabeth Kubler-Ross. Englewood Cliffs, N.J., Prentice-Hall, 1978. 160 p. \$12.95.

### SOCIOLOGY

**Suicide, Theory and Clinical Aspects:** L.D. Hankoff, ed. Littleton, MA, Publishing Sciences Group, 1979. 464 p. \$32.50.

### GENETICS

**Human Genetics:** Symposium on genetics and human biology. New York, Excerpta Medica, 1979. 425 p. (Ciba Foundation Symposium, 66) Gift.

### HUMAN ANATOMY

**Human Embryology, A Regional Approach:** M.J.T. Fitzgerald. New York, Harper and Row, 1978. \$15.00.

### BIOCHEMISTRY

**Nutrition in Medical Practice:** Robert E. Hodges. Philadelphia, Saunders, 1980. 363 p. \$20.00.

### PHARMACOLOGY

**The Anticancer Drugs:** William B. Pratt. New York, Oxford University Press, 1979. 323 p. \$8.95.

### PRACTICE OF MEDICINE

**Harrison's Principles of Internal Medicine:** T.R. Harrison, ed. 9th ed. New York, McGraw-Hill, 1980. 2 v.

**Hospice:** Kenneth P. Cohen. Germantown, Md., Aspen Systems Corporation, 1979. 302 p. \$22.75.

**Modern Nutrition in Health and Disease:** Robert S. Goodhart and M.E. Shils, ed. 6th ed. Philadelphia, Lea and Febiger, 1980. 1370 p. \$47.50.

### COMMUNICABLE DISEASES

**The Biologic and Clinical Basis of Infectious Diseases:** Guy Youmans and others. 2nd ed. Philadelphia, Saunders, 1980. 849 p. \$19.50.

**Principles and Practice of Infectious Diseases:** Gerald L. Mandell and others. New York, John Wiley and Sons, 1979. 2 v. \$72.00.

### IMMUNOLOGIC DISEASES

**Allergy and Clinical Immunology:** Richard F. Lockey. Garden City, N.Y., Medical Examination Publishing Co., 1979. 1193 p. \$35.00. Gift.

### MUSCULOSKELETAL SYSTEM

**Clinical Biomechanics of the Spine:** Augustus A. White. Philadelphia, Lippincott, 1978. 534 p. \$45.00.

**The Hip:** Hip Society. St. Louis, Mosby, 1979. 334 p. \$29.50.

**Injuries of the Knee Joint:** Ian S. Smillie. 5th ed. New York, Churchill Livingstone, 1979. 360 p. \$59.50.

**Myotonic Dystrophy:** Peter S. Harper. Philadelphia, Saunders, 1979. 331 p. (Major problems in neurology, v. 9). \$29.00.

**Neurology of Musculoskeletal and Rheumatic Disorders:** Kenneth K. Nakano. Boston, Houghton-Mifflin, 1979. 401 p. \$40.00.

**Symposium on Arthroscopy and Arthrography of the Knee:** American Academy of Orthopaedic Surgeons. St. Louis, Mosby, 1978. 352 p. \$47.50.

**Symposium on Microsurgery, Practical Use in Orthopaedics.** American Academy of Orthopaedic Surgeons. St. Louis, Mosby, 1979. 387 p. \$42.50.

## HEALTH ISSUES BEFORE THE 1980 LEGISLATURE

### THE CONTENT OF BILLS CHANGES FROM DAY TO DAY, SO TELEPHONE CMS FOR AN UPDATE ON ANY BILL OF INTEREST TO YOU.

*Air Pollution:* Auto emissions control is being addressed in eight different bills including one requiring that a certain percentage of classroom hours in driver education courses be devoted to the role of motor vehicles in causing air pollution and the benefits of alternative means of transportation. CMS has conceptually supported the bills but has not testified on any bill.

*Arthritis:* There is a bill establishing an arthritis educational outreach program under the health department and providing for a fellowship in rheumatic diseases at the medical school.

*Certificate of Need:* Two certificate of need bills attempt to bring Colorado's certificate of need law into compliance with the federal law. One speaks only to HMO's, the other to a wide variety of amendments. CMS feels that the HMO amendments give too great an advantage to those groups and thus opposes that bill.

*Child Abuse:* Six bills attempt to tighten the current child abuse law. Full disclosure of records when a report appears to have been maliciously made; the degree of evidence required when separating a child from his parent or guardian; distinguishing the criminal penalty when abuse results in death; the development of public school programs to curtail and prevent child abuse; and the broadening of the definition of abuse are the subjects addressed. CMS supports these bills.

*Cost Containment:* Identical bills were introduced in the Senate and House to extend the life of the Colorado Hospital Commission and develop detailed proposals and techniques for hospital cost containment. Both bills have died. Another defeated bill would have implemented at the University Hospital an educational program designed to teach providers of health services the methods of medical cost containment. A different approach to cost containment exempts from sales tax the sale of eyeglasses, hearing aids, dental appliances and fil-

lings, and numerous other devices necessary for the treatment of illness, injury, or disability. It has a minimum price tag of \$900,000.

*Emergency Medicine:* One seemingly harmless bill excluding vehicles and attendants for the emergency transportation of persons injured at a mine from the stipulation of the Colorado Emergency Medical Services has become a matter of concern to CMS. The poorly trained attendant is a real worry.

*Medically Indigent Insurance:* Four bills address the critical medical indigency problem. Two of them began all-inclusive competing bills with incentives for employers to insure their employees plus coverage for the unemployed, the "uninsurable", and the victims of catastrophic illness. Now, one of these contains the financing mechanism; the other contains the programmatic description. One other bill speaks to the immediate problems of hospitals with high medically indigent populations, and the fourth bill allows the faculty practice fund at the medical school to bill any insurance program that evolves from all of this legislation. CMS supports all of these bills.

*Nurse Practice Bill:* The nurse practice bill was killed last year and must be passed in some form this year if there is to be licensure. The bill has been changed many times, and our concerns are being addressed.

*Parking for Handicapped:* Two bills amend the definition of "handicapped person" so as not to require the need for a mechanical device. Special parking would also be granted to temporarily handicapped persons. CMS supports both bills.

*Physician Salaries:* Physicians in the state personnel system may be hired or retained at a higher maximum salary than at present if this bill passes. CMS is supporting this long-overdue increase.

#### OUR COVER

The American country doctor, according to painter August Lenox, whose "The Doctor's Last Call" is our March cover, "has never before been put on the pedestal where he belongs - I don't think there was any one facet of the settling of the West which was more beneficial to humanity than that man with his horse and buggy or his saddle and horse, who went around trying to take care of sickness, gunshot wounds, accident victims, and everything else. Some of them rode more than fifty miles one way to get to the patient."

Lenox, a native of South Dakota, worked as ranch hand and wilderness guide, and during the depression rode the rails before becoming an illustrator for the U.S. Coast Guard. Lenox now is engaged in painting a series on the Early Western Doctor, others of which we are happy to report will be seen on the cover.

Prints of the picture can be ordered through *Colorado Medicine* at the price of \$65.00. Make your check for \$65.00 to Vignette Corporation, filling out and enclosing the card to be found between pages 118 & 119 and sending it to:

**Colorado Medicine, 1601 East 19th Avenue, Denver, Colorado 80218.**



# Diagnostic confusion created by positive monospot tests

Jonathan E. Kaplan, MD, and Richard Gillespie, MD, Albuquerque, New Mexico\*

*A positive Monospot test is ordinarily considered specific for infectious mononucleosis. The group of cases here described suggests that a positive Monospot test may not be specific, and that this test may cause confusion in diagnosis. Possible explanations for the false-positive Monospot test are discussed.*

The diagnosis of infectious mononucleosis is ordinarily based upon characteristic clinical findings (fever, malaise, pharyngitis, adenopathy) and laboratory data (lymphocytosis with atypical lymphocytes, heterophile antibodies, Epstein-Barr virus antibody). With regard to serology, rapid slide agglutination tests (i.e. Monospot; Ortho Diagnostics, Raritan, N.J.) have achieved widespread use due to their high sensitivity, and to the ease with which they can be performed in the laboratory or office setting. A high level of sensitivity, however, is frequently associated with a loss of specificity, and although the Monospot test is designed to exclude Forssman and serum sickness heterophile antibodies, false positive tests have been reported in leukemia, lymphoma, pancreatic carcinoma, rheumatoid arthritis, sarcoidosis, rubella, cytomegalovirus and adenovirus infections, serum hepatitis, malaria, epilepsy, and normal individuals.<sup>1-8</sup> These reports vary, of course, in degree of case documentation, and in most instances it has been difficult to rule out recent mononucleosis.

We have recently encountered a group of patients in whom diagnosis was difficult, and in whom the occurrence of positive Monospot tests added to the confusion.

## CASE REPORTS

**Case 1:** T.M., a 19-year-old woman, was admitted to the hospital in October, 1977 with a two week history of malaise, fatigue, and anorexia, and a three day history of diarrhea. Three weeks earlier she had shared a drinking glass with a friend who had been jaundiced. On physical examination she was icteric and had an enlarged uterus consistent with a 35 week pregnancy. The liver was palpable, but not tender and not enlarged. No pharyngitis, adenopathy, or splenomegaly was noted. CBC revealed a white count of 7500 with 75 PMN's, 1 band, 12 lymphocytes, 9 monocytes, and 3 eosinophils; no atypical lymphocytes were seen. Liver function tests showed SGOT 56 (5-20), alkaline phosphatase 236 (20-65), bilirubin 5.0 total, 3.7 direct. Urinalysis was positive for bilirubin. Hepatitis antigen was negative. Monospot was weakly positive, and three days later was negative (both samples were run on the second occasion, and the original result was confirmed). The patient subsequently recovered, and delivered a normal infant.

**Case 2:** J.H., a 19-year-old man, housemate of T.M., was seen in the outpatient department, while T.M. was hospitalized, with a ten day history of fever, malaise, fatigue, anorexia, nausea, dark urine, and sore throat. He had the same prior exposure as T.M. Physical examination disclosed fever (38.5 degrees), icterus, and a palpably tender liver that was not felt to be enlarged. There was no pharyngitis, adenopathy, or splenomegaly. WBC was 5500 with 68 PMN's, 27 lymphocytes, 3 monocytes, 1 eosinophil, and 1 basophil. No atypical lymphocytes were seen. SGOT was 1592 (5-20), alkaline phosphatase 138 (20-65), bilirubin 5.0 total, 3.8 direct. Hepatitis antigen was negative. Monospot on two occasions was negative. The patient subsequently recovered, although at last testing, the SGOT remained elevated (65 in December, 1977).

**Case 3:** B.C., a 28-year-old woman, sister and housemate of T.M., was seen in the outpatient department with a ten day history of malaise, fatigue, anorexia, nausea, and swollen glands. She shared the same prior exposure with T.M. and J.H. Physical examination showed non-tender bilateral cervical adenopathy. There

\* Department of Medicine, University of New Mexico School of Medicine, Albuquerque, New Mexico.

was no icterus, pharyngitis, or hepatosplenomegaly. CBC was never performed. Liver function tests revealed SGOT 48 (5-20), alkaline phosphatase 59 (20-65), bilirubin 0.5 total, 0.3 direct. Hepatitis antigen was negative. Monospot was positive. The patient recovered uneventfully.

**Case 4:** P.J., a 48-year-old woman, paternal grandmother of T.M.'s two year old son, was seen in the outpatient department with a four day history of intermittent fever, malaise, fatigue, anorexia, and sore throat. She had no known history of hepatitis or mononucleosis, and her only recent exposure was to her grandson, who, although a housemate of T.M., J.H., and B.C., was never clinically ill. Physical examination revealed mild pharyngitis. There was no icterus, adenopathy, hepatosplenomegaly, or fever. CBC showed a white count of 9400 with 53 PMN's, 42 lymphocytes, and 5 monocytes. No atypical lymphocytes were seen. SGOT was 25 (5-20), alkaline phosphatase 85 (20-65), bilirubin 1.2 total, 0.4 direct. Hepatitis antigen was negative. Throat culture was negative. Monospot was weakly positive. The patient felt well four days later.

**Case 5:** P.J., a 26-year-old woman, daughter of P.J. (Case 4), was seen by a private physician for a one week history of fatigue, anorexia, sore throat, and swollen glands. She had no known history of hepatitis or mononucleosis, and her only recent exposure was to T.M.'s son, and to P.J., her mother. Physical examination showed pharyngitis and cervical adenopathy, but no icterus or hepatosplenomegaly. A CBC was not performed. Liver function tests were within normal limits. Monospot was weakly positive. The patient recovered uneventfully.

## Discussion

The cause of illness in these patients is unknown, although it would seem likely that it was infectious, and that all the patients had the same infection. However, J.H.'s illness (Patient 2) was consistent with infectious hepatitis, while B.C.'s and P.J.'s illnesses (Patients 3 and 5) were suggestive of infectious mononucleosis. Although four of the five patients had positive Monospot tests, none of the blood counts performed suggested mononucleosis.

What then, are the sources of the positive Monospot tests in Patients 1, 3, 4, and 5? These patients could have had mononuc-

leosis; perhaps they developed mild illnesses without the characteristic blood picture. Certainly unrecognized infections with Epstein-Barr virus occur, and they can be associated with a positive Monospot and a normal blood count.<sup>9</sup> Case 1, however, was not a mild illness; furthermore, most authorities would agree that the diagnosis of clinically apparent infectious mononucleosis is untenable without a suggestive blood smear. Another possibility is that these patients had had mononucleosis in the past. Horwitz<sup>9</sup> has presented evidence suggesting that Monospot positivity may persist several months, or even years following infection. This would be an unlikely explanation in our clustered group of patients. Finally, there remains the possibility that the tests were performed incorrectly. Herbert<sup>10</sup> recently reported several such instances. The Monospot in our cases, however, was performed as directed, using the appropriate controls and technic, and using reagents well within their respective expiration dates.

There is a question whether the positive Monospot tests in our cases represented non-specific false positives. It is interesting to note in this regard that many of the disorders for which false positive Monospot tests have been reported involve damage to reticuloendothelial tissues. Wahren<sup>5</sup>, in fact, hypothesized that heterophile antibodies represent a non-specific response to virus in the host's tissues. We wonder whether these antibodies may be even more non-specific than suggested, since several of the disorders mentioned above are non-viral, and even non-infectious. Certainly much remains to be known about the source of heterophile antibodies in man.

Our cases indicate that a positive Monospot, like other laboratory test, must be interpreted with caution. ●

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## HELMET LAW REPEAL HAS SAD - PREDICTABLE - CONSEQUENCES

By repealing its motorcycle helmet law in 1977, Colorado removed, as a requirement, the most significant protection available to motorcyclists.

The bleak harvest of repeal has been a doubled death rate for motorcyclists on Colorado highways: 78 in 1979, compared with 35 in 1976.

A less apparent, but no less appalling, result is the upsurge in disabling head and neck injuries incurred by unprotected cyclists. Emergency rooms across the state are seeing twice the number of serious head injuries to victims, mostly teen-aged, of the new "freedom" granted by repeal.

The suffering experienced by the predominantly youthful victims and their families is shared financially by all Coloradans. In 1978, Colorado motorcycle accidents cost over \$20 million; 60% of this cost was borne by tax-supported medical care programs.

Historically, the Colorado Medical Society has supported mandatory helmet usage. This year, the support will take the form of participation in a drive to secure at least 70,000 signatures on petitions which will bring the issue to a referendum vote in November. The Colorado Medical Society, the Colorado Medical Society Auxiliary, and a number of medical and general organizations are cooperating in the effort. Should you wish to take part, please call Ray G. Witham, M.D., President, Colorado Medical Society.

## MEDICALLY INDIGENT LEGISLATION MAY BE PRICED OUT OF THE MARKET FOR THE NEEDY

HB 1226, Medically Indigent bill, was, this week (March 3, 1980) passed out of the House of Representatives, Colorado General Assembly. Good news in one sense, but not such good news in other areas. Legislators who usually vote with the peripheral health groups, as well as those legislators who are fearful of the bill's cost, voted to include chiropractics, optometrics and podiatry. The legislators seemed to feel that by decorating the bill with as many benefits as they could think of they could price the bill out of consideration. That may be the case, but it is too early to tell. Meantime, Jack Warren, M.D., Chairman of the Colorado Medical Society's Council on Legislation, told Colorado Medicine:

"We (CMS) have supported the legislation for the medically indigent because we are very concerned about the fact that there are so many Coloradans without medical insurance. Without this insurance these people are liable to be without needed medical treatment.

The inclusion of chiropractors, optometrists and podiatrists in the legislation should be a consideration of cost-containment: Medically indigent legislation should be capable of administration on a sound financial basis. If tangential treatments are included, then the patients are not going to receive the best medical care. The cost to the general public will be much higher."

Comments heard around the House lobby included: If the members were worried about the cost of the legislation, all they had to do was to put a cost limit on it themselves. They could easily have done this, since the bill is an Appropriations matter."

## COLORADO GOVERNOR STRESSES HEALTH NEEDS IN STATE'S FUTURE

Colorado Governor Richard Lamm, in his welcoming address to the delegates of the 45th Annual Winter Clinics of the Colorado Medical Society, pointed up the growing health responsibilities of state government during the coming 20 years. In doing so, Governor Lamm stressed the need for continued cooperation between members of the Medical Society and his offices. Lamm pointed to the fact that among all the major problems facing the state, including air pollution, rural health needs, energy impact (either the shortage of or the search for more), hazardous waste disposal among the foremost, the health and well being of Coloradans was the fastest growing need in terms of state dollars. Lamm stressed the point that his budget planning was fragmented at every turn because of the growing need for public health care services. He pointed out the present concern for the medically indigent, the need for increased salaries for state-employed physicians, the need for more state dollars in the operation of Denver General Hospital and similar institutions, the difficulties brought on by the court rulings concerning Colorado State Penitentiary facilities, etc. Governor Lamm emphasized the theme that "It is the kind of problem that we have in terms of not doing enough to promote physical fitness, well-being, nutrition, non-smoking, reducing the use of alcohol...and we've got to do more than that."

Governor Lamm noted that "We're going to add another 1-point-2 million people (to Colorado's population) within the next 20 years. We estimate we're going to invest (or see invested) more money in Colorado in the next 15 years than was invested in the entire last hundred years." He added that executives of Public Service Company of Colorado had told him "they will need more capital investment in the next five years than they've needed in the past 110 years." The Governor warned of an increasing problem within the state institutions, pointing to the current situation at the University of Colorado Health Sciences Center. He said "We really have a significant problem in terms of what do we do now, for the fourth year in a row when we are, in fact, really squeezing down on a number of our Colorado institutions that took us a hundred years to build up. And, for the fourth year in a row, we are operating government on less per-capita dollars. I really feel, with some credibility, that there's been more tax relief given during my five years as Governor than at any other time in Colorado's history, but I'll tell you this is a time now when we're going to have to spend some more money.....not less. We're going to have to resist the temptation to give everybody back this year \$3.42. Instead, really spend some money making sure that we can maintain the excellence of our institutions."

## LOST AND FOUND

"Please check your closet. Found - man's black wool coat. Leather gloves in pocket, no belt, Neusteter's label. Lost - woman's black wool coat. Leather gloves in pocket; belt in back, Neusteter's label. Both at CMS Interim Session March 2. Call Colorado Medical Society to exchange."



## COLORADO MEDICAL FOUNDATION TRUST MAKES GIFT FOR PUBLIC HEALTH EDUCATION

The Colorado Medical Foundation Trust, in December, 1979, declared that four gifts would be presented to health-oriented organizations in Colorado. Distribution was made from interest earned by the Foundation Trust funds. Organizations which received the gifts were all Colorado charitable 501 (c) 3 organizations, including the Colorado Heart Association, Colorado Diabetes Association, the Hall of Life (Colorado Health Education and Information Center, Incorporated), and Amigos de las America.

The Hall of Life, founded by Leo J. Nolan, M.D., Lakewood, received a gift of \$2,000.00 to go toward the purchase of the first and most important exhibit, known as "TAM." TAM is an acronym for Transparent Anatomical Mannequin, which is a 5'9" transparent plastic sculpture of the human female, wired and assembled in such a manner that each of the human's functions are shown as TAM talks about that function. TAM has been hailed in other parts of the United States as one of the finest health training concepts yet devised. TAM is also bilingual (English and Spanish), speaks in terms for elementary-school aged children or in lengthened, more detailed fashion for adult audiences.

TAM will be one of several exhibits which will be displayed in the Hall of Life, located on the main floor of the Blue Cross/Blue Shield Building, 700 Broadway, Denver. The exhibits will be displayed in such a fashion that the viewers literally "sit down" and are transported to each of the exhibits.

The Hall of Life has already gleaned support from such organizations and corporations as Johns-Manville, Clear Creek Valley Medical Society, Colorado Medical Society, United Bank of Denver, Blue Cross-Blue Shield, IBM Corporation, and many others.

Ray G. Witham, M.D., President, Colorado Medical Society, presented the CMS check for \$2,000.00 to Mary Baca, Vice President, and Leo J. Nolan, M.D., Founder and President of the Hall of Life, in late-February, to help in the initial payments on TAM. As a result of this and other gifts, TAM was brought to Denver some three months earlier than had been expected.

TAM was designed and custom manufactured by the Richard Rush Studios of Chicago, and is one of a number of such exhibits now in museums and health-education centers in the U.S.

Already planned to accompany TAM is a rear-screen audio-visual display that will further tell the story of health education and care and treatment of the human body.

Soon to be added to the Hall of Life displays is a video tape program with large-screen viewing, so that Hall of Life participating physicians and related professional health care agencies can produce their own educational segment to show visitors. If your organization would like to be represented and participate by creating a display in the Hall, contact Hall of Life, 831-2950, in Denver, or contact Bill Pierson, Director of Communications, Colorado Medical Society, 861-1221.

## WHITE HOUSE POLICY PLACES EMPHASIS ON NATIONAL HEALTH ISSUES

National health policy should "take into account those states which have started their own hospital cost containment activities," stated James J. Mongan, M.D., in an interview with Colorado Medicine on March 1st. Mongan, the Associate Director for Health and Human Resources of the Domestic Policy Staff at the White House, address the membership of the Colorado Foundation for Medical Care at the 45th Annual Winter Clinics in Denver. Colorado Medicine was there to discuss with Dr. Mongan the aspects of national health policy and their relationship to the newly-formed Department of Health and Human Services.

Mongan said that the ground work is being laid by the Senate Finance Committee so that federal health services and cost containment reform legislation can proceed in the next session of Congress.

National health insurance legislation was recently voted down by Congress, but Mongan said the Administration did not consider this a defeat. He said his policy group would continue to work for passage of the bill, but alterations would have to be made. The proposal in the next session would be targeted at special areas of health service, such as insurance for low-income families which are not eligible for Medicare; cost control and reform to stimulate insurance competition; a catastrophic health plan to benefit employers and their employees; and, emphasis on health education for preventive services.

Mongan, pleased with HEW's controversial split into two departments, says of the arrangement: "It should improve the new Department of Health and Human Services' ability to focus on the health and welfare issues. I think we're beginning to see some of that already. The primary concerns of the new department are medical financing, health insurance and hospital cost containment. Programs which will be implemented in the near future are: the Children's Health Assurance Program (CHAP), which is aimed at improving the quality of health care for low-income children; the Mental Health Systems Act; and, a health manpower proposal, aimed at improving the way we support medical education and the education of allied health professionals."

On the subject of the HMO as a possible alternative to a national health insurance policy, Mongan agrees that Americans need to have a choice in health care plans; however, HMOs "are difficult organizations to get started....they take capital, they take dedicated personnel. It is going to be a long haul to get organizations of that sort started, so I don't think it is prudent to base national policy on the hope that there will be these kinds of competitive alternatives present in all parts of the country in the next five to fifteen years."

Dr. James Mongan was, for seven years, a staff member to the Senate Finance Committee responsible for Medicare, Medicaid and National Health Insurance Legislation. He also served two years as Deputy Assistant Secretary of Health, Education, and Welfare. His Denver address took place during the Colorado Medical Society's Winter Clinics.



PUBLISHED JOINTLY BY THE COLORADO FOUNDATION FOR MEDICAL CARE, COLORADO MEDICAL SOCIETY AND THE COLORADO ACADEMY OF FAMILY PHYSICIANS • 1601 EAST NINETEENTH AVENUE, DENVER, COLORADO 80218

## MARCH 1980

### 27th

**HEMODYNAMIC MONITORING IN CRITICAL CARE.** Denver Hilton Hotel. Contact: Office of Postgraduate Medical Education, University of Colorado Health Sciences Center, 4200 E. 9th Ave., Denver, CO 80262. 394-5241. (6 hours of AMA Category 1 credit).

## APRIL 1980

### 13th-16th

**BASIC COURSE, PRACTICAL CLINICAL HYPNOSIS.** Lake Dillon, CO. Contact: Wallace LaBaw, M.D., P.C., 2045 Franklin - Suite 100, Denver, CO 80205. (303) 892-1181.

### 16th-19th

**GRADUATE CLINICAL HYPNOSIS SEMINAR.** Lake Dillon, CO. Contact: Wallace LaBaw, M.D., P.C., 2045 Franklin - Suite 100, Denver, CO 80205. (303) 892-1181.

### 23rd

**COLORADO REGIONAL NEURORADIOLOGY & COMPUTERIZED TOMOGRAPHY MEETING.** University Hospital, Denver. Contact: Leatha Kibel, Department of Radiology, University Hospital, 4200 E. 9th Ave., Denver, CO 80262. 394-7773. (3 hours of AMA Category 1 credit).

### 25th

**NONINVASIVE CARDIOLOGY FOR THE NONCARDIOLOGIST.** The Inn at Loretto, Santa Fe, New Mexico. Contact: Ann B. Sei, Office of Continuing Medical Education, The University of New Mexico School of Medicine, North Campus-Building M2, Albuquerque, New Mexico, 87131 or (505) 277-3942. (10 hours AMA 1, or 10 hours AAFP).

### 26th

**ROCKY MOUNTAIN DIVISION OF AMERICAN COLLEGE OF SPORTS MEDICINE.** Auditorium, Poudre Valley Memorial Hospital, 1024 Lemay, Fort Collins, CO 80524. Contact: John Harvey, M.D., 484-4871 or 482-4111, ext. 1550. (7 prescribed hours of AMA Category 1 credit).

### 28th

**HEMATOLOGY-ONCOLOGY EMERGENCIES - PART II.** Burlington, CO. Contact: Martin J. Rubinowitz, M.D., The Denver Clinic, 701 East Colfax Ave., Denver, CO 80203. (2 hours of AMA Category 1 credit; 2 prescribed hours of AAFP credit).

## MAY 1980

### 3rd

**AMBULATORY MEDICINE: CURRENT TREATMENT OF COMMON OFFICE PROBLEMS.** Kaiser-Permanente, Lakewood Medical Office, 8383 W. Alameda, Lakewood, CO. Contact: James Adams, M.D., 232-1885. (5½ hours of AMA Category 1 credit).

### 9th-10th

**AMERICAN COLLEGE OF SURGEONS ANNUAL MEETING.** The Broadmoor, Colorado Springs. Contact: Vi Brown, Colorado Medical Society, 1601 E. 19th St., Denver 80218. 861-1221, ext. 241.

### 28th

**COLORADO REGIONAL NEURORADIOLOGY & COMPUTERIZED TOMOGRAPHY MEETING.** University Hospital, Denver. Contact: Leatha Kibel, Department of Radiology, University Hospital, 4200 E. 9th Ave., Denver, CO 80262. 394-7773. (3 hours of AMA Category 1 credit).

### 31st

**COLORADO CHAPTER OF THE ACADEMY OF PEDIATRICS ANNUAL MEETING.** Four Seasons, Colorado Springs. Contact: Vi Brown, Colorado Medical Society, 1601 E. 19th St., Denver 80218. 861-1221, ext. 241.

### 30th-June 1

**COLORADO OTOLARYNGOLOGY & MAXILLOFACIAL AND NEW MEXICO EAR, NOSE & THROAT SOCIETY ANNUAL MEETING.** The Broadmoor, Colorado Springs. Contact: Vi Brown, Colorado Medical Society, 1601 E. 19th St., Denver 80218. 861-1221, ext. 241.

## JUNE 1980

### 7th

**DOWN'S SYNDROME WORKSHOP & DINNER.** Denver. Contact: Colorado Child & Adolescent Society, 1601 E. 19th Ave., Denver, CO 80218. 861-1221, ext. 241.

### 9th-14th

**26th ANNUAL FAMILY PRACTICE REVIEW.** Estes Park, Colorado. Contact: Office of Postgraduate Medical Education, University of Colorado Health Sciences Center, 4200 E. 9th Ave., Denver, CO 80262. 394-5241.

### 13th

**HEMATOLOGY/ONCOLOGY.** Denver. Contact: Office of Postgraduate Medical Education, University of Colorado Health Sciences Center, 4200 E. 9th Ave., Denver, CO 80262. 394-5241.

### 22nd-26th

**3RD INTERNATIONAL SYMPOSIUM: CANCER THERAPY BY HYPERThEMIA, DRUGS & RADIATION.** Colorado State University, Fort Collins. Contact: W. C. Dewey, Ph.D., Department of Radiology & Radiation Biology, Colorado State University, Fort Collins, CO 80523. (303) 491-5096.

### 25th

**COLORADO REGIONAL NEURORADIOLOGY & COMPUTERIZED TOMOGRAPHY MEETING.** University Hospital, Denver. Contact: Leatha Kibel, Department of Radiology, University Hospital, 4200 E. 9th Ave., Denver, CO 80262. 394-7773. (3 hours of AMA Category 1 credit).

### 28th-July 1

**NEUROLOGY.** Aspen. Contact: Office of Postgraduate Medical Education, University of Colorado Health Sciences Center, 4200 E. 9th Ave., Denver, CO 80262. 394-5241.

### 30th-July 3rd

**CACMLE POSTGRADUATE CONFERENCE IN CLINICAL LABORATORY PRACTICE.** Hilton Harvest House, Boulder. Contact: Elmer W. Koneman, M.D., Colorado Association for Continuing Medical Laboratory Education, Inc. (CACMLE), 1601 Milwaukee St., Denver, CO 80206. (303) 321-1734.

# HOLISTIC HEALTH CARE - WHO IS DOING WHAT?

An informational membership meeting ("Constituency Night") on this subject will be held by the Denver Medical Society, Tuesday, June 3. A Task Force on Holistic Health has been making itself aware of the varying approaches to this volatile subject since July 1979. The Denver area is a hotbed of practitioners of various kinds operating under the umbrella of "holistic health". Some of the questions to be addressed are:

Is there a specific time when "holism" started?

Preventive medicine - what is it?

What do we mean when we say: "Treating the whole person"?

What are some of the methods being espoused for patients to reach "optimal attunement of body, mind, emotions and spirit"?

Are physicians capable of judging the scientific soundness of different holistic health approaches?

Where do "wellness clinics" and "health motivation centers" fit into the picture?

What are the purposes and goals of organizations such as the American Holistic Medical Association and the Colorado Holistic Health Network?

Participants in the program will include the chairman of the Task Force, a member of the American Holistic Medical Association and physicians practicing as consultants in health evaluation, enhancement, and maintenance.

## HIGHLIGHTS FROM PROPOSED BME REGULATIONS

The Colorado Board of Medical Examiners has just approved a new set of regulations governing continuing medical education requirements for physicians.

**Here are some highlights:**

1. Physicians will not be required to report CME hours accumulated during **calendar 1979** because the law was changed in the middle of that year. License renewal papers now in the mail make this clear.
2. Next year (calendar 1980) and thereafter, "20 clock hours" of CME will be required.
3. Those 20 hours **must be reported each year** at the time of license renewal.
4. Hours in excess of 20 earned in one year cannot be counted toward meeting the following year's requirements. There's no carry-over.
5. What kind of hours can be counted for the 20 hour requirement? Hours offered by a program that is "... sponsored or certified by the American Medical Association, the American Osteopathic Association, the American Association of Family Physicians, or state affiliates of such organizations". That means — essentially — AMA/Category 1 or AAFP prescribed hours.
6. What other kinds of hours can be counted toward the requirement?
  - Time spent in a "mini-residency" at the medical school or at an institution accredited for continuing medical education.
  - Time spent teaching in an approved (accredited) program of continuing medical education.
  - Time spent in an approved internship or residency program.
7. All the other AMA categories of CME credit no longer count for the state requirement.

If you have questions about all this, call the Board of Medical Examiners or Kevin Bunnell, Director, Division of Continuing Education, Colorado Medical Society, at 861-1221 x 262 (or toll-free outside metropolitan Denver at 1-800-332-4150 x 262).



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Editorial and Business Office  
1601 E. 19th Ave.  
Denver, Colorado 80218  
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*Colorado Medicine* (ISSN-0199-7343) is published monthly for \$12 per year by  
the Colorado Medical Society, 1601 East 19th Avenue, Denver, Colorado, 80218.  
Second-class postage paid at Denver, Colorado. POSTMASTER: Send address  
changes to *Colorado Medicine*, 1601 East 19th Avenue, Denver, Colorado 80218.

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Advertising: National representative: John H. Harling, Inc., 8 South Michigan  
Avenue, Chicago, Illinois 60603. Telephone: (312) 641-9755.

# president's letter

## Some Reflections on the Winter Clinics.

I wish all of you had had the opportunity to observe the House of Delegates sessions from the vantage point of the podium. It was an exciting experience.

First, there is the moment of stage fright, which passes quickly (even without aid of tranquilizers), and then the concern that all of the events will go as planned. Usually, they do go as planned, thanks to the planning done by your staff, with many hours spent in the effort.

What interested me most was the intensity of feeling expressed by the Delegates. I also sensed a deep interest in coming to grips with new problems as well as old. Every session I'm seeing new faces and new expressions. The more of this, the better!

Mason Howard (your President Elect) and I, along with some of your staff people, are going to make every effort possible to visit your component society meetings at least once this year. It has been a tough winter for travel, but things are looking up with spring here. We are looking forward to seeing as many of you as possible this spring and summer. The visits are one of my enjoyable tasks. I have found that each component society has its unique personality.

By the time you read this I am hopeful that the Helmet Law initiative will have several thousand signatures on it. The entire matter has been a torment in my mind; an issue for which there can be bitter legal issue out of what any sensible individual would provide for himself: safety and protection against injury. But the whole issue apparently focuses on the matter of individual rights versus prudent, safe, personal behavior. Somewhere in this question of personal freedom we are losing sight of the fact that personal behavior so often impinges on the individual freedom of many other persons. Therefore, the injury suffered by one person while enjoying that "individual freedom" is likely to rob many other persons of their freedom for days, weeks, even years to come.

We live in a society of majority rule. Why, then, must we, the majority, pay for the "freedom" and expression of "Macho individualism" of a small minority. Statistics will show that the majority of people in Colorado are bearing the untold expenses



and heartache in loss of productivity, loss of personal property, and the heroic efforts of physicians to save lives of brain-injured motorcycle riders who refused to wear protective headgear. We are constantly reminded of the effect the sick, injured and dying have on family, friends, community and medical attendants. Personal injury is really not personal.

Would you, as a physician, choose to demand to express your personal freedom, your individual right, by refusing to follow proven medical practice simply because you don't like to wear a surgical mask in the operating room? The exercise of your individual right of free choice will surely affect the lives of others, and so you elect to say "My personal freedom is my desire and my ability to serve humankind; therefore, I elect to practice those simple but effective surgical mandates for the protection of others."

No, freedom does not mean the inalienable right to "do my thing" without regard to the effect it will have on those around me. The meaning of freedom is just as much a meaning of responsibility to the good of the majority. I believe you all know and accept this in your daily practice of medicine. Our freedom, as physicians, is to alert people to the dangers of those injuries resulting from motorcycle accidents.

Somewhere, we are losing sight of just whose freedom we are tampering with: the person who expresses no concern for his or her personal safety, or the many persons on whom the lifelong effect of this irresponsibility falls. Let's stand for the freedom of the majority; the freedom from the burden of paying the emotional, the monetary and the social costs of unnecessary death and injury of a minority.

*Ray L. W. Peterson*

## OUR COVER

This weather-beaten New Mexican pueblo is typical of the Navajo dwellings in which ancient medical teachings war with modern medicine. Within these adobe walls generations upon generations of Navajo have learned how to ward off evil spirits. Cathy Bell's article on "The Navajo Patient" on page 83 details the confrontation of Navajo teachings and modern medicine's active practices.



# at press time ...

## COLORADO LEGISLATURE WINDING DOWN AS END OF LONG "SHORT" SESSION NEARS

Things are moving slowly at the Capitol as they always do in the last month or six weeks of a session. The House has handled relatively simple bills on the floor so that the majority Republicans could spend much of the time writing a tax relief package. The agreed-upon proposal totals about \$197 million; it excludes Representative McElderry's medically indigent proposal, HB 1150, and includes Representative Traylor's HB 1092, exempting a number of medically necessary items from sales tax.

The Senate, in the meantime, introduced a new auto emissions control bill under the SB52 title, and has been moving it along at a steady pace despite much rhetoric. The testing of automobiles would begin as a program for state vehicles in the front range area and would progress over a several year period to include all automobiles. Of course it is hoped that the automobile industry will have our problems taken care of by then. The first real test of strength came when Senator Cole (R), Littleton, moved to strike the enacting clause of the bill, thus killing it. The vote to oppose this motion was 23 to 11, and the bill rolled on to the House. Several crippling amendments were added in the Senate - hopefully, these will be removed or compromised in the bill's remaining steps in the process.

After the crises that reared its head last week when the Joint Budget Committee came up with its initial figures for the medical school, a "summit conference" was held between concerned medical parties and Senator Kadlec (D), Greeley. He became convinced that he and his fellow JBC members had indeed set incorrect figures and scheduled a second meeting with Senator Hughes (R), El Paso, and Representative Neale (R), Denver. The final version gives the school \$7 million instead of the \$5.6 million in last week's version; it no longer allows transfer or appropriation of funds from the Family Practice Fund; it gives the physicians \$750,000 for treatment of the medically indigent. In return the school must agree not to make a supplemental budget request in the next fiscal year; it must withdraw its request for \$1.0 million from Representative Neale's HB 1227, which reimburses hospitals for medically indigent care; it will support a two-year phase-in of the principle that tuition be increased to 25% of the cost of medical education. (With the help of the veterinarian school at C.S.U., we may be able to achieve a five-year

## COLORADO LEGISLATURE WRAPUP (Continued)

phase-in); it will let die HB 1138, Representative Gorsuch's (R), Denver, bill allowing the Family Practice Fund to bill a medically indigent insurance program.

Three lengthy committee meetings have been held to rewrite HB 1226, the "big" medically indigent bill. Senator Hughes has greatly simplified it; reference to other health practitioners is removed, and the policies have been patterned after the state employee policies with a similar board deciding content. Parts 4 and 5 will probably be eliminated when the bill is heard in the Senate HEWI committee (At press time, that hearing was scheduled for 3:30 p.m., April 1st. Careful monitoring of that committee meeting is deemed editorially necessary, since the meeting was to fall on April Fool's Day.) Part 4 attempts to set up a risk pool for uninsurables; part 5 tries to spell out certification of medicare supplemental policies but now appears to hurt rather than help. Catastrophic coverage remains in the bill and may be all that remains when the dust settles.

Fred Volkema from Bethesda and lobbyist Carol Tempest split a \$1 entry in the pool guessing the day and hour when the legislative session ends. They chose April 26th at 8:30 p.m. Carol says that annually she seems to guess a date two weeks early, but Fred has been around the capitol much longer than Carol, so their combined effort might be rewarded. Some members of the general assembly are not so optimistic about the adjournment date; they're still saying some time in May.

## COLORADO MEDICAL SOCIETY COMES OUT STRONG FOR THE RETURN OF THE HELMET LAW

Colorado Medical Society Board of Trustees approved the expenditure of \$5,000 toward forming a coalition of interested parties, allied health care providers and organizations pledged to working to return the motorcycle helmet law to Colorado. This initiative will require the collection of more than 63,000 valid signatures by July 7, 1980, to insure that the initiative would be placed on the November ballot. A total of 62,234 eligible voter signatures are required. The petition has been filed with the Secretary of State's office, and had been approved by the appropriate state officials as of March 21st.

Colorado Medical Society has already set about establishing a committee of interested parties, organizations and allied health care providers to



## HELMET LAW (Continued)

conduct the petition drive, outside of the Society, itself.

There has already been a strong showing of support; however, there's also a very busy group of opponents to the initiative and to the law. The Medical Society Board of Trustees stipulated that if there wasn't enough additional support from groups outside the Society, the Board will consider withdrawing its support to the petition drive.

# CONTINUING MEDICAL EDUCATION CALENDAR

PUBLISHED JOINTLY BY THE COLORADO FOUNDATION FOR MEDICAL CARE, COLORADO MEDICAL SOCIETY AND THE COLORADO ACADEMY OF FAMILY PHYSICIANS • 1601 EAST NINETEENTH AVENUE, DENVER, COLORADO 80218

## **MARCH 1980**

### **27th**

**HEMODYNAMIC MONITORING IN CRITICAL CARE.** Denver Hilton Hotel. Contact: Office of Postgraduate Medical Education, University of Colorado Health Sciences Center, 4200 E. 9th Ave., Denver, CO 80262. 394-5241. (6 hours of AMA Category 1 credit).

## **APRIL 1980**

### **13th-16th**

**BASIC COURSE, PRACTICAL CLINICAL HYPNOSIS.** Lake Dillon, CO. Contact: Wallace LaBaw, M.D., P.C., 2045 Franklin - Suite 100, Denver, CO 80205. (303) 892-1181.

### **16th-19th**

**GRADUATE CLINICAL HYPNOSIS SEMINAR.** Lake Dillon, CO. Contact: Wallace LaBaw, M.D., P.C., 2045 Franklin - Suite 100, Denver, CO 80205. (303) 892-1181.

### **23rd**

**COLORADO REGIONAL NEURORADIOLOGY & COMPUTERIZED TOMOGRAPHY MEETING.** University Hospital, Denver. Contact: Leatha Kibel, Department of Radiology, University Hospital, 4200 E. 9th Ave., Denver, CO 80262. 394-7773. (3 hours of AMA Category 1 credit).

### **25th**

**NONINVASIVE CARDIOLOGY FOR THE NONCARDIOLOGIST.** The Inn at Loretto, Santa Fe, New Mexico. Contact: Ann B. Sei, Office of Continuing Medical Education, The University of New Mexico School of Medicine, North Campus-Building M2, Albuquerque, New Mexico, 87131 or (505) 277-3942. (10 hours AMA 1, or 10 hours AAFP).

### **26th**

**ROCKY MOUNTAIN DIVISION OF AMERICAN COLLEGE OF SPORTS MEDICINE.** Auditorium, Poudre Valley Memorial Hospital, 1024 Lemay, Fort Collins, CO 80524. Contact: John Harvey, M.D., 484-4871 or 482-4111, ext. 1550. (7 prescribed hours of AMA Category 1 credit).

### **28th**

**HEMATOLOGY-ONCOLOGY EMERGENCIES - PART II.** Burlington, CO. Contact: Martin J. Rubinowitz, M.D., The Denver Clinic, 701 East Colfax Ave., Denver, CO 80203. (2 hours of AMA Category 1 credit; 2 prescribed hours of AAFP credit).

## MAY 1980

### 3rd

**AMBULATORY MEDICINE: CURRENT TREATMENT OF COMMON OFFICE PROBLEMS.** Kaiser-Permanente, Lakewood Medical Office, 8383 W. Alameda, Lakewood, CO. Contact: James Adams, M.D., 232-1885. (5½ hours of AMA Category 1 credit).

### 7th

**ANTICOAGULANTS - WHAT YOU SHOULD KNOW.** Estes Park. Contact: Martin J. Rubinowitz, M.D., The Denver Clinic, 701 E. Colfax Ave., Denver, CO 80203. (2 hours of AMA Category 1 credit; 2 prescribed hours of AAFP credit).

### 9th-10th

**AMERICAN COLLEGE OF SURGEONS ANNUAL MEETING.** The Broadmoor, Colorado Springs. Contact: Vi Brown, Colorado Medical Society, 1601 E. 19th St., Denver 80218. 861-1221, ext. 241.

### 28th

**COLORADO REGIONAL NEURORADIOLOGY & COMPUTERIZED TOMOGRAPHY MEETING.** University Hospital, Denver. Contact: Leatha Kibel, Department of Radiology, University Hospital, 4200 E. 9th Ave., Denver, CO 80262. 394-7773. (3 hours of AMA Category 1 credit).

### 31st

**COLORADO CHAPTER OF THE ACADEMY OF PEDIATRICS ANNUAL MEETING.** Four Seasons, Colorado Springs. Contact: Vi Brown, Colorado Medical Society, 1601 E. 19th St., Denver 80218. 861-1221, ext. 241.

### 30th-June 1

**COLORADO OTOLARYNGOLOGY & MAXILLOFACIAL AND NEW MEXICO EAR, NOSE & THROAT SOCIETY ANNUAL MEETING.** The Broadmoor, Colorado Springs. Contact: Vi Brown, Colorado Medical Society, 1601 E. 19th St., Denver 80218. 861-1221, ext. 241.

## JUNE 1980

### 7th

**DOWN'S SYNDROME WORKSHOP & DINNER.** Denver. Contact: Colorado Child & Adolescent Society, 1601 E. 19th Ave., Denver, CO 80218. 861-1221, ext. 241.

### 9th-14th

**26th ANNUAL FAMILY PRACTICE REVIEW.** Estes Park, Colorado. Contact: Office of Postgraduate Medical Education, University of Colorado Health Sciences Center, 4200 E. 9th Ave., Denver, CO 80262. 394-5241.

### 13th

**HEMATOLOGY/ONCOLOGY.** Denver. Contact: Office of Postgraduate Medical Education, University of Colorado Health Sciences Center, 4200 E. 9th Ave., Denver, CO 80262. 394-5241.

### 19th

**COMMON RASHES.** Vail. Contact: Martin J. Rubinowitz, M.D., The Denver Clinic, 701 E. Colfax Ave., Denver, CO 80203. (2 hours of AMA Category 1 credit; 2 prescribed hours of AAFP credit).

### 22nd-26th

**3RD INTERNATIONAL SYMPOSIUM: CANCER THERAPY BY HYPERTHEMIA, DRUGS & RADIATION.** Colorado State University, Fort Collins. Contact: W. C. Dewey, Ph.D., Department of Radiology & Radiation Biology, Colorado State University, Fort Collins, CO 80523. (303) 491-5096.

### 25th

**COLORADO REGIONAL NEURORADIOLOGY & COMPUTERIZED TOMOGRAPHY MEETING.** University Hospital, Denver. Contact: Leatha Kibel, Department of Radiology, University Hospital, 4200 E. 9th Ave., Denver, CO 80262. 394-7773. (3 hours of AMA Category 1 credit).

### 28th-July 1

**NEUROLOGY.** Aspen. Contact: Office of Postgraduate Medical Education, University of Colorado Health Sciences Center, 4200 E. 9th Ave., Denver, CO 80262. 394-5241.

### 30th-July 3rd

**CACMLE POSTGRADUATE CONFERENCE IN CLINICAL LABORATORY PRACTICE.** Hilton Harvest House, Boulder. Contact: Elmer W. Koneman, M.D., Colorado Association for Continuing Medical Laboratory Education, Inc. (CACMLE), 1601 Milwaukee St., Denver, CO 80206. (303) 321-1734.

## JULY 1980

### 7th-10th

**OPHTHALMOLOGY: "PROBLEMS IN PEDIATRIC OPHTHALMOLOGY".** Vail. Contact: Office of Postgraduate Medical Education, University of Colorado Health Sciences Center, 4200 E. 9th Ave., Denver, CO 80262. 394-5241.

### 7th-11th

**16TH ANNUAL POSTGRADUATE COURSE IN INTERNAL MEDICINE.** Estes Park, Colorado. Contact: Office of Postgraduate Medical Education, University of Colorado Health Sciences Center, 4200 E. 9th Ave., Denver, CO 80262. 394-5241.

### 16th-20th

**SUMMER SKIN SEMINAR.** Aspen. Contact: Office of Postgraduate Medical Education, University of Colorado Health Sciences Center, 4200 E. 9th Ave., Denver, CO 80262. 394-5241.

### 18th-20th

**CURRENT TOPICS IN ANESTHESIOLOGY: PHARMACOLOGY FOR THE YOUNG & OLD.** Keystone. Contact: Office of Postgraduate Medical Education, University of Colorado Health Sciences Center, 4200 E. 9th Ave., Denver, CO 80262. 394-5241.

### 31st-August 3rd

**PEDIATRICS.** Snowmass. Contact: Office of Postgraduate Medical Education, University of Colorado Health Sciences Center, 4200 E. 9th Ave., Denver, CO 80262. 394-5241.



# The Navajo Patient

## Illumination of Cultural Differences

Cathy Bell, R. EEG T., Albuquerque, New Mexico.

*A variety of cultural backgrounds exists in every patient population, some vastly different from our own personal experience. The Navajo nation, approximately 148,000 people, offers a dramatic display of how customs and folkways can alter the individual's view of medicine. The traditional religion/medicine of the Navajos, with its concepts of environmental disharmony, witchcraft, and ceremonials is discussed in hopes of providing a better understanding of the cultural differences we must deal with as health care professionals.*

### The People

The majority of the Navajo people reside on the 18,000,000 acres comprising their reservation in Arizona, Utah, and New Mexico, the largest in the United States. Many of their beliefs and manners of daily living have remained similar to those established when they first occupied the area, around 1000 AD. Important to understanding the Navajo is the knowledge of how he views himself. "Navajo" is a Spanish word originating with the 17th century Franciscan friars; their own word for themselves is "dine", The People.<sup>4</sup> The term reflects the strong sense of belonging and purposeful origin found in The People's way of life and religion. It also illuminates the uniqueness with which they regard their own humanity.

The Navajo outlook on life is a unified one blending religious, social, and medical ideologies with the environment, with the maximum emphasis being placed on the curing of sickness. A harmony of all of these elements must exist to maintain the sense of well being; therefore, when the Navajo is ill it is a sign that he is out of step with his total environment, and disharmony exists. This disrupted harmony may have occurred for several different reasons: the mishandling of animals or seeing wolves or coyotes,

being too close to lightning or to a dead person, improper behavior during ceremonials, infection from non-Navajos, or contact with a ghost.<sup>10</sup> Every ailment, mental or physical is a reflection of this disharmony and not of local disease. To lay blame for an illness on a specific body part is a concept unknown to Navajo thought; most Navajos don't even know the Navajo words to label body organs.<sup>12</sup> If the cause of the ailment cannot be traced to one of the previously mentioned transgressions, the origin is then often ascribed to witchcraft.



On a frame hardly different from that used by an ancestor centuries ago, this Navajo woman weaves with wool colored by dyes coming from a blend just as ancient.

### Witchcraft

Witches are men or women — evil people believed to practice incest — who deliberately cause illness in others sometimes from jealousy and hatred, sometimes to force the patient to pay for the proper ceremony to cure him.<sup>5</sup> Sickness is created in the victim by procuring a portion of the victim, i.e., strands of hair, nail pieces, feces, urine, or clothing and uttering a spell over these body parts, or by shooting small objects into him. Symptoms which frequently give evidence of witchcraft range from emaciation, localized sharp pain, anxiety, fainting and seizures, to death.<sup>3</sup>

Miss Bell was at the Bernalillo County Medical Center, Albuquerque, New Mexico, and now is with the Grass Instrument Company, Quincy, Massachusetts.

Those illnesses believed to have been caused by witchcraft are most effectively cured by the witch confessing to the deed but with the expected absence of such, chants and prayers are performed for the afflicted. The degree in which a Navajo may believe in witchcraft is an individual matter and a very personal one. Physicians who deal with the Navajos on or near the reservation generally assume a belief in witchcraft on the part of their patients and even the very "acculturated" Navajo will harbor strong regard for it.<sup>2</sup>

### *Seizures*

Seizures have a unique social role in the medicine/religion of The People in that, depending upon the type of seizure experienced, it may indicate the victim to be a shaman-like diagnostician, to have committed incest, or have been cursed by a witch. The kind of seizure which carries a positive connotation is that which would involve trembling of either hand or both. The "hand-trembler" is used in Navajo medicine as a diagnostician employed to determine the etiology of illnesses. However, they have largely been found to be hysterics rather than epileptics.<sup>8</sup> The dreaded and disgraceful seizure type is "ichaa", usually a generalized convulsion, the presence of which indicates that incest may lie in the patient's past. It is also feared because the patient may lie rigid and unresponsive in a tonic phase and appear "like he's dead sometimes" with the associated misgivings. The Navajo patient who has been found in trance-like states or non-purposeful behavior (psychomotor seizures) is believed to have been a victim of witchcraft and is therefore not stigmatized.<sup>8</sup>

Because of the religious — mystical emphasis placed on seizures in the Navajo culture it is felt by some that there is a larger percentage of hysterical seizure patients among the Navajo, and that these seizures would most likely have the appearance of the focal or psychomotor type.<sup>1</sup> Hysterical seizures may be found more often also in the diagnosed seizure patient. The stigma which coexists with the seizures can cause "mean things" to be said about him. The patient may turn a hostile face towards his people and find he can use his seizures to frighten them intensely.

### *Fear of the Dead*

For The People a second great fear exists, a fear of the dead. It is believed that with birth a life force or "spirit" enters the body to reside until death, at which time the remaining energy, or "ghost", is released.<sup>11</sup> Since this "ghost" needs both time and space to make the transition from life to death, it is disrespectful and dangerous to be intimately involved with this transition. One who is contaminated by this death spirit will experience a disruption of the harmony in his world as punishment by the spirit for transgressions against the deceased. This potential for harm causes most Navajos to avoid dealing with the dead as much as possible to the point that a death occurring in the hogan necessitates the body be removed through a hole in the wall to the north or that the hogan be destroyed. Even the traditional mourning process is abbreviated to consist of 4 days for reserved expression of grief following which the mourner is expected to resume his daily routine without further verbal or emotional expression toward the loss.<sup>7</sup> This fear of the dead and prohibition against mourning and grief can cause conversion symptoms to develop following a death. Those who by necessity had to attend the corpse of a friend or relative who has died of cerebral tumor or abscess with associated head pain may develop psychosomatic headaches and then would fear affliction by the same evil supernatural influences that caused the death.



Receiving modern-day care is a hardship to the Navajo, raised within an ancient framework of personal references.



## *Traditional Navajo Healing*

Once the source of the illness has been determined, it is necessary to restore the harmony of natural and supernatural relationships by treating the *cause* of the illness (the dysharmony), not the symptoms, by arranging a ceremony or "sing" for the afflicted. There are approximately 35 different ceremonies for the purpose of restoring harmony which are performed by medicine men who have spent many years memorizing each detail of the different ceremonies. These may last from 1 to 9 nights or until the symptoms are relieved. The curing includes the use of plant medicines, pharmacological studies have shown some to have therapeutic properties,<sup>13</sup> sweat baths for purification of body and mind, songs, chants and prayers are said over the patient. Drypaintings are frequently included in a curing ceremony.



Always the sand paintings by the Navajo medicine men have been key elements in warding away the evil spirits which bring disease.

They are made of charcoal and minerals on a sand or buckskin background. Once it is completed, the patient sits upon it and with ceremony he is temporarily linked to the Gods. During his illness the patient is the focus of all attention and is ministered to by family and friends. He is well fed and cared for, and watched over continuously by the medicine man.

## *Confronting American Medicine*

With this illustration of native Navajo medicine in mind, it is possible to begin to understand the misgivings and fears which con-

front the Navajo when he approaches the medicine of the non-Navajo doctor and his hospital. The hospital is looked upon as a place where people go to die, a place hopelessly contaminated with death.<sup>11</sup> In fact, if death appears inevitable for a relative, the family may admit him so the death can occur in the hospital, thereby avoiding damage or destruction of the hogan which would have been necessary had the death occurred there. Another disadvantage with which physicians and hospitals must cope is the resistance of The People to hospital admission until after the serious illness has had an attempted cure by a ceremonial with the loss of precious time so that the illness has become critical and a cure very difficult to insure. In less life threatening cases in which the Navajo has chosen admission there remains a great deal for him to experience.

The interruption of daily routine while in a hospital is upsetting to every patient but even more confusion awaits the Navajo patient. He is frequently unaccustomed to living by the clock, is not used to staying in one place, and also feels that a man lying down in the daytime is a lazy man. It is difficult to be content with broth and crackers when, if he were home, he would be fed the best available and as much of it as his family could offer. He receives the attention of his doctors and nurses for only short periods during the day instead of the continuous vigilance given him by his family group and the medicine man. It is also difficult for him to understand why, if this medicine is going to cure him, it is not given to him all at once instead of only little bits a few times a day. The customary change into hospital gown is humbling to The People as they are very sensitive to body exposure and do not generally follow the practice of changing clothing for bed.<sup>3</sup> For the purpose of running routine hospital tests it is necessary to extract from the patient blood, urine, and other body material. As previously mentioned, these substances can also be used to invoke harm on the individual if in the hands of evil people but the Navajo is able to excuse this possibility by believing hospital personnel to be oblivious to this potential. (This also is true for hair that may be shed during the routine EEG.)

To establish personal interaction and to obtain a medical history from the Navajo can be a very trying experience for doctor or technician. Cultural standards dictate that direct eye contact is a personal intrusion and impolite; be-

cause the patient is staring at the ground does not mean he isn't listening. Excessive appreciation and enthusiasm for what may be done would be felt to be bad formal manners, quiet appreciation is more natural. In a new situation where custom does not tell him how to behave the Navajo patient may choose to be stoical and withdraw in hopes the uncomfortable situation will go away. Or he may choose to escape from the source of the uneasiness and pressure, as in the case of the hospital, and leave. It is particularly evident in the history taking that there exists a divergence of conversational habits of the Navajo from the non-Navajo, i.e., a question presented to him may typically receive one of two responses. Should it be too personal or mindless he will offer no response at all and should the question be a perceptive one it will still receive no *immediate* reply, since it would be worthy of time spent in deliberation before answering. (The Navajos have learned to imitate the habit of saying "uh" to relieve the anxieties of the interviewer and fill in this time lapse.) Add to this the assumption that if the inquisitor is smart enough to be a doctor, or clever enough to make that big machine work, he shouldn't need to ask all those questions. Another obstacle that exists in the history taking procedure is the suspicion that bringing up past illnesses and those of relatives can generate a recurrence of the sickness. Seizures, fits, fainting spells have been discussed and evidenced to be the mark of witchcraft or incest; it is possible therefore, to see how this area of questioning calls for a very sensitive approach. As in the case with all people, time taken to explain the illness and treatments or tests will ease apprehensions. Time spent discussing un-

related pleasantries is evidence of concern for the patient's general well being, and the use of a caring, attentive, and hopeful attitude will all help to obtain the best results.

### Comments

Just as we are able to see the world around us changing daily, the life of The People is changing. It is becoming vital that they make economic, political, and social transitions to adapt to the non-Navajo world. Though their religious/medical views have changed only slightly, a rise of confidence for the non-Navajo medicine is evidenced by the ability of both non-Navajo doctor and medicine man to work together. More patients come willingly to the hospital for immediate care knowing that the proper ceremonial is available for the patient when he returns home. Also, in recent years the non-Navajo doctor has accepted the fact that therapy by ceremonial and medicine man can be as necessary for a cure as any treatment he may offer.

Some beliefs of the Navajo people may seem foreign and remote. But it is hoped that this illustration will suggest that within any group of people a potential exists for many cultural differences, be they of ancestry, religion, or politics. These need to be understood and respected before health care can be performed with best effect. ●

### ACKNOWLEDGMENT

Sincere appreciation is extended to Dr. Robert Bergman for helping me develop the idea of creating this paper, and for his contributions to it. My thanks are also given to Dr. Barry Silbaugh.

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## Assistance for the Impaired

The Committee on Physician Health and Rehabilitation will begin planning workshops to train Physician Advocates in late March. Faculty, format, and locations of the workshops are among subjects to be discussed by the Committee, chaired by John S. Avery, MD.

A roster of Advocates will be recruited from CMS members who wish to equip themselves for the task of motivating impaired physicians to seek treatment. Trained Advocates, with involvement and responsibility primarily in their own communities, will meet occasionally with the central Committee when cases warrant discussion.

A second goal of the Committee this month is the preparation of an informative program to be presented to interested component medical societies and auxiliaries. Literature and talks by Committee members will be made available throughout Colorado to assure awareness of the structure and the opportunities afforded by the program.

Dr. Avery says that the Committee hopes to hear from members who are interested in participating in the effort to build a statewide team of Physician Advocates, trained to intervene and stem the course of impairment.

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## obituaries

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Doctor **Lawrence Tracy Brown** died on March 4, 1980 at the age of 85.

Doctor Brown was born August 5, 1894 in Norfolk, Nebraska, and after his family moved to Denver, he attended public schools, graduating in 1913 from East High School. He received a BA from the University of Colorado in 1923, then took an MS in physiology in 1927 at the University of Illinois.

In 1930 he received an MD from Rush Medical College in Chicago, following which he interned at West Suburban Hospital at Oak Park, Illinois, and then established a General Practice in Denver. Since 1945 Doctor Brown had limited his work to obstetrics and gynecology. He retired in 1972.

Doctor Brown was vice president of both the Denver and Colorado Medical societies, and served for sixteen years as a delegate to the Colorado Medical Society from the Denver Medical Society.

He served as a Captain in the Army Field Artillery from 1917 to 1919, and from 1935 to 1942 as a Lieutenant Colonel in the Field Artillery.

Doctor Brown is survived by his wife, Esther Longstreth Brown, and three daughters, Margaret Brown Little, of Arvada; Marion Brown Crabb, Devon, Pennsylvania; and Kathryn Sue Gates, Portland, Oregon, and by his brother, the newscaster Winsor W. Brown of Sarasota, Florida.

## For The One Man In 100



A bow tie devotee values the unique skill of knotting his own tie, and for you, Grassfield's Gano-Downs offers a most extensive selection. Our spring silk stripes and foulard prints are light, fresh, and follow today's narrower line. Visit any of our three locations while collections are complete.



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# the lobby

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*What is a Keyman Program?* It is one of the most meaningful parts - the key - of a successful legislative and public relations program and one we must re-vamp soon. It begins with a relationship between a legislator and a person who has a strong belief in something, but a combination of any legislator and any believer does not necessarily work. In other words, it must be a "meaningful relationship" that is based on trust, faith, and belief in each other. The relationship may start between school friends, between neighbors, between sports companions, within shared political activities, and in a thousand other ways. But somehow it is a "meaningful relationship" and I, as your lobbyist, need to know about those relationships!

Seriously - we have a close-relationship problem. Physicians historically have not had the time or desire to work politically, either at the campaign level or at a lobbying level. Few have been members of groups such as Rotary, United Way campaigns, volunteer movements, political party organizations - physician hours and dollars have been sadly lacking. Even in groups with no volunteer hour commitment, physicians haven't had the time to join in the camaraderie.

Thus, all of a sudden, things have caught up with us. As a 1,000% believer in physicians, I am having to answer very negative statements and votes by legislators who have been *Keymanned* by the chiropractors, optometrists, podiatrists, nurses, social workers, et al. With what appeared to be limited horizons, these specialty groups, years ago, set long-range goals based on a step-at-a-time until equality with physicians is achieved. Each step looks so tiny but has meant so much. Part of the process involved has been creating an ongoing relationship with every candidate, be he the winner or loser. The groups, with their *Keyman*, have combined efforts masterfully and as a combination know which legislator has come to believe in one or another of the practitioners. It's a tough act to beat!

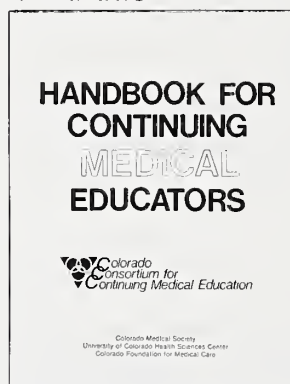
The immediate answer goes back to the political system that we treat with such carelessness. Every one of us must attend his precinct caucus on May 5 - it only takes a call to your county election commission or court house to find the address of your neighbor who is hosting it. You will find it enjoyable and the way to be elected to go on as a delegate or alternate to your county assembly. Most importantly, you will suddenly be the physician who has never before bothered to attend. Wow!

I can lobby only so hard as a lobbyist paid by your dues. I am willing to spend 12, 14, even 18-hour

days doing this, but I am only as strong as the *Keyman*. I haven't missed going to my caucus - and county assembly - and state convention for twenty years. I even tried to go to the national convention but failed because I backed the wrong presidential candidate. But I tried - and it's the trying that other delegates remember. So, go to your twentieth or your first caucus, go to your twentieth or first convention - and work in some way in a legislative campaign. Then you'll be a real *Keyman* - you'll be a key to the future of medicine and you just might command the key 33rd vote in the House or the key 18th vote in the Senate - and those numbers mean victory.

*Carol Tempest*

## Handbook for Continuing Medical Educators To Be Available



A *Handbook for Continuing Medical Educators* will be published this month as an aid to all those involved in CME who are interested in evaluating and possibly upgrading their own CME programs.

The handbook is a service of the Colorado Consortium for Continuing Medical

Education, developed in 1978 as a pooling of the talents and interests of the Colorado Medical Society, the Colorado Foundation for Medical Care, and the University of Colorado Health Sciences Center, its sponsors.

To obtain a copy, phone Kevin Bunnell, EdD, Director, Colorado Consortium for Continuing Medical Education, (303) 861-1221, X 262 (In Colorado, but outside Denver metro area phone 1-800-332-4150) or clip and return the form below:

Dr. Bunnell,

I am interested in the *Handbook for Continuing Medical Educators*. Please get in touch with me at (phone) \_\_\_\_\_

Or write to me: \_\_\_\_\_

Contents include such topics as Finding Out What Education is Needed, Choosing the Right Methods for Teaching and Learning, Evaluating The CME Teacher, Evaluating the Effect of an Educational Program on Participants, and Using a Patient Data System to Plan and Evaluate Continuing Medical Education. A listing of CME resources is also included.



# Ovarian abscess in mid-trimester\*

Stephen A. Myers, DO, Denver, Colorado; Enrique Benavides, MD, Laredo, Texas;  
Dharam P. Alrenga, MD, and Uwe Freese, MD, Chicago, Illinois

Although changing patterns in sexual behavior and contraception have led to an increase in the rate of severe pelvic infections, ovarian abscess fortunately remains uncommon. Wilson and Black report twelve cases of ovarian abscess in 75,000 gynecologic admissions, all in either the post-abortion or post-partum period.<sup>1</sup> For such to occur in mid-pregnancy is rare; only four cases have been reported in the literature.<sup>2-4</sup> A fifth case is presented with the discussion of the diagnostic dilemma and considerations of possible pathophysiologic mechanisms.

## CASE REPORT

A 36 year old black female, G-4, P-0-0-3-0, presented with a chief complaint of eleven months amenorrhea and lower abdominal pain. The patient had normal menses every 30 days lasting 4-5 days until 14 months prior to admission. At that time, she was seen by a gynecologist with two months amenorrhea and told she was pregnant, possibly with twins. Two months later, when seen for vaginal bleeding after a car accident, she was told she was not pregnant. She had one episode of spotting four weeks later, the only vaginal bleeding for eleven months prior to admission.

The pain was diffuse, sharp, non-radiating, and present for one week. It had become more severe in the preceding twelve hours. She had vomited once but denied any other gastrointestinal or any urinary tract symptoms. Three weeks prior to admission she had been treated for "infections in her urine" with sulfisoxazole and metronidazole.

She had two prior spontaneous abortions at 2-3 months gestation with curettage after each. She was known to be hypertensive but took no medication.

Admission examination showed an anxious female in moderate distress, reluctant to admit to any illness. Her blood pressure was 144/90, pulse 90/min., respiration 22, temperature 99.2. She weighed 230 pounds. The abdomen was distended. There appeared to be a large abdominopelvic mass with questionable rebound pain and guarding. Bowel sounds were hypoactive. No fetal heart tones could be heard. External genitalia, vaginal vault, and cervix were normal. On bimanual examination, the cervix was very tender to motion. The cul-de-sac was filled with a tender, round, smooth, regular, semi-fixed 8 x 10 cm mass not completely distinguishable from the uterus. The remainder of the physical examination was unremarkable.

Laboratory data showed a positive pregnancy test, Hct. 37%, WBC 8,000 with differential count not immediately available. Urine analysis showed granular hyaline casts and no WBC or bacteria. Chest X-ray was within normal limits and X-ray of the abdomen was interpreted as having no fetus, a distended large bowel, and a pelvic mass.

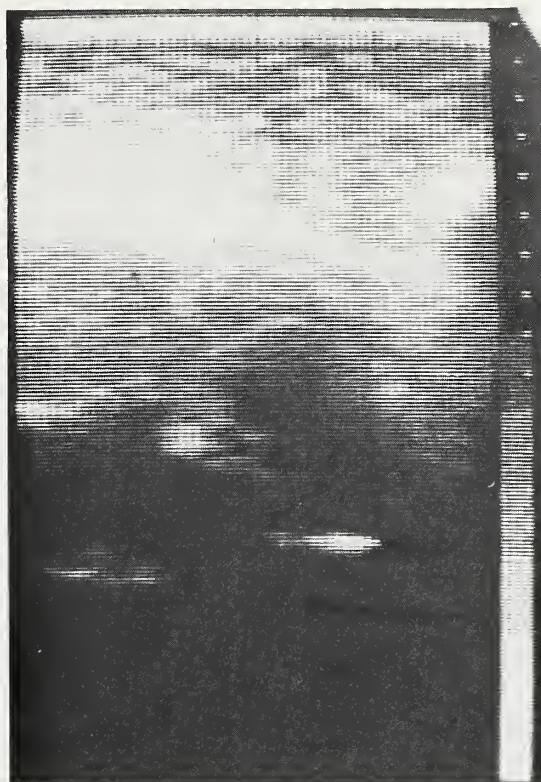


Fig. 1. A mid-line, longitudinal scan; the patient's head is to the left and her feet to the right. The fetal thorax and head are seen below the uterine wall echo. Note the multiple vertical acoustic shadows overlying the fetus, and the large dark area posterior to the fetal head.

Real time ultrasound was performed. A longitudinal section demonstrated a viable intrauterine pregnancy of approximately 20 weeks gestation in the cephalic presentation. FHT's were 140. (see Fig. 1)

During the subsequent 16 hours of observation the patient's condition was unchanged. Differential WBC showed 6 bands, 33 polymorphonuclear cells, 6 eosinophiles, and 55 lymphocytes. Two hours later the patient spontaneously expelled a 340 gm fetus and placenta intact. Her abdomen immediately became less distended and the pain diminished. Because of the marked improvement and uncertain diagnosis, observation was continued. However, 12 hours later the patient's condition took a sudden turn for the worse. She developed chest pain and shortness of breath and developed accelerated hypertension with blood pressure 250/140, respiration 30, pulse 110 and temperature 99.6. Abdominal examination now showed marked guarding with rigidity and warranted immediate exploration. Pelvic examination disclosed some dark blood in the partially dilated cervix; the cul-de-sac mass was unchanged. The uterus

\*From the Departments of Obstetrics and Gynecology and Pathology, The Chicago Medical School/Cook County Hospital. For reprints: Stephen A. Myers, DO, Division of Perinatal Medicine, University of Colorado Health Sciences Center, 4200 East Ninth Avenue - B-199, Denver, Colorado 80262.

could not be definitely outlined because of the pain. Initial arterial blood gases were compatible with a large shunt although this improved markedly with oxygen and was attributed to atelectasis. Central and arterial lines were placed and ampicillin, gentamicin, clindamycin, and nitroprusside were begun. Once the patient was stabilized, the exploratory laparotomy was performed. A leaking abscess was discovered arising from the right adnexa. The remaining puerperal pelvic viscera and the appendix appeared secondarily infected. Because the origin of the infection was felt to be the uterus and because subsequent fertility was not important to the patient, hysterectomy, bilateral salpingo-oophorectomy and appendectomy was performed.

The postoperative course was unremarkable and the patient was discharged on the eleventh postoperative day on alfa-methyl dopa, hydrochlorthiazide and a potassium supplement.

Cultures of the abscess grew E-coli, *Bacteroides fragilis* and peptostreptococcus. Pathologic examination of the specimen revealed a right ovarian abscess, perisalpingitis, a normal uterus, and periappendicitis (see Fig. 2).

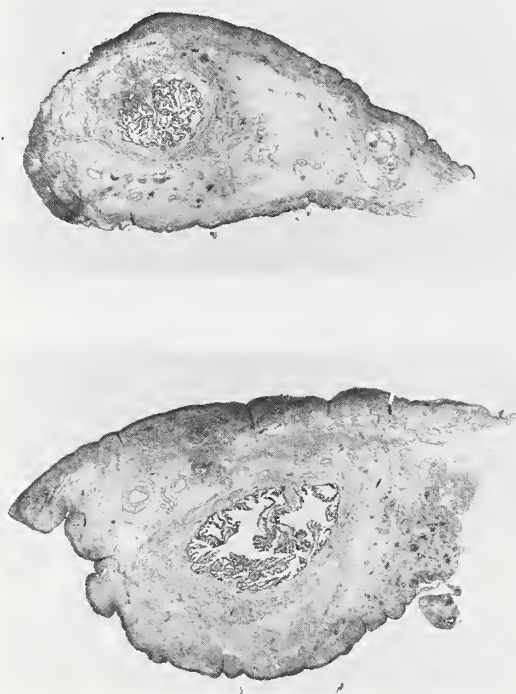


Fig. 2. Composite microphotograph of fallopian tubes (right at top, left at bottom) showing delicate mucosal regae and absence of inflammatory changes (hematoxylin and eosin, x 4.5).

## Discussion

The coexistence of an ovarian abscess and mid-pregnancy is associated with considerable morbidity. Of the four cases previously reported, there was one maternal death prior to antibiotic therapy,<sup>4</sup> and only one surviving infant.<sup>2</sup> In this last case, reported by Friedman and Bobrow, the patient was explored at 28 weeks gestation and an ovarian abscess was removed. She recovered and later delivered a live infant at term.

Our diagnostic dilemma and subsequent therapeutic delay was characterized by the conflicting data, not unusual in patients with pelvic infection during pregnancy. Initially, the patient's symptoms were mild and the laboratory data non-diagnostic. The symptomatic improvement after spontaneous abortion obscured the picture and delayed definitive diagnosis and treatment. It is not uncommon for abdominal sepsis to cause abortion.

The ultrasound deserves further comment. Dilated loops of bowel throwing acoustic shadows and the edematous omentum overlying the uterus made adequate resolution of the more posterior echoes nearly impossible. The large sonolucent area posterior to the head and anterior to the sacrum was originally interpreted as artifact. In fact, this was the abscess cavity.

An ovarian abscess, as distinct from a tubo-ovarian abscess, remains a patho-physiologic enigma. Unlike abscesses associated with infection from the lower genital tract, only conjecture exists about possible etiology. The following possible mechanisms have been suggested by Hunt<sup>5</sup>; hematogenous spread, lymphatic spread, infection in a pre-existent ovarian cyst, or flare up of old post abortal infection. In the present case, the last explanation seems unlikely since the patient developed her symptoms antepartum. The microbiology of the abscess may be a clue. Other than bowel, the vagina and cervix are the only possible sources of such an inoculum. We suggest, therefore, that vascular or lymphatic spread of cervical organisms could have accounted for the pathologic state in this patient. Why the right ovary was primarily affected is unknown.

Only with great hesitancy is the diagnosis of pelvic infection in pregnancy entertained, although certainly this can occur. Only four prior times has the diagnosis of ovarian abscesses in late pregnancy been made. The diagnosis of an ovarian abscess is almost always an operative and histologic diagnosis. It is rarely, if ever, diagnosed pre-operatively. To occur in mid-trimester, in the absence of instrumentation or predisposing pelvic or gastrointestinal pathology, is truly unusual. ●

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# Emergency Benevolent Fund

The purposes of the Emergency Benevolent Fund as well as the mechanics of applying for use of the fund are widely misunderstood. This fund was established in 1942 by members of the Colorado Medical Society Auxiliary as a means of providing for immediate temporary financial assistance to an auxiliary spouse and minor children, an individual or family in dire financial need.

The income derives from the Auxiliary's own accrued interest and designated gifts which are received from time to time. Disbursal is at the discretion of the Emergency Benevolent Fund Committee, composed of the past three state auxiliary presidents.

All requests are held in strict confidence, and applicants are identified by number rather than name. Two things should be noted: it is an outright gift and not a loan, and it is temporary in nature rather than a long-term matter.

The Fund is open to any dues-paying Auxiliary member. Application can be made to the state committee directly, or to the president of the local medical auxiliary in which the applicant carries membership. An immediate investigation of the circumstances of the family is carried out, and assistance given as quickly as possible.

In this time of high inflationary costs and sometimes low-income producing situations we want all Auxiliary members to know this assistance is available to them, should the need arise. Keep in mind that a widowed Auxiliary member in good standing can apply as well as a family. Since county presidents usually know their members, I would ask them to be aware if a need for help exists.

Jean Twombly  
Chairman, Emergency Benevolent Fund

## new members

**Southeastern:** Ivan D. Wright and Brian P. Massaro.

**Northeast:** Larry G. Stahl and James W. Ley.

**Pueblo:** Benjamin A. Gitterman.

**Otero:** Lairie O. Stabler, Benton F. Murphy, III and John W. Dodson.

**Mesa:** Gary L. Snyder, Bronwen J. Magraw and Enno F. Heuscher.

**El Paso:** Charles E. Stewart, Constant V. Platz and Emmett M. Bentley.

**Mt. Sopris:** William Bowman, Jr.

**Denver:** Robert L. Sain, James E. Reeves, Paída K. Reddy, Burley J. Packwood, Diane Nugent, Stephen S. Nicholson, Randall D. Miller, Mary T. McNary, James A. McArthur, Stephen A. Mann, Stephen Shealy, Gerardo Magallon, Leighton Larsson, Andrew Lozano, Jr., Lee E. Krauth, Fredrick Hanson, Jeffrey B. Fowler, Michael G. Firth, Dennis Eicher, James E. Christman, Diana Funderbunk-Burns, Richard E. Albin and Arlis M. Adolf.

**Boulder:** Susan M. O'Brien, James A. Davidson and Frederick B. Danziger.

**Arapahoe:** Joshua R. Pushkin, Joseph M. Long, Harry H. Hill and Michael Persoff.

**Adams-Aurora:** William A. Solomon.

**Boulder County Medical Society:** Susan M. O'Brien, James A. Davidson and Frederick B. Danziger.

**Arapahoe County Medical Society:** Joshua R. Pushkin, Joseph M. Long, Harry H. Hill and Michael Persoff.

**Adams-Aurora Medical Society:** William A. Solomon.

## Colorado Medical Society Placement Service

As a benefit for current and potential members of the Colorado Medical Society, we now offer an improved, more efficient placement service for those physicians seeking practice opportunities in Colorado. By utilizing a newly-programmed computer system timely and accurate "matching" of opportunity listings and physicians seeking opportunities in Colorado can be achieved. To arrive at maximum exposure of position listings and applicants registering with the placement office, CMS is soliciting input from the Colorado Specialty Societies and the Governor's Office of Rural Health. To maintain current and accurate listings within the placement service, registrants desiring to list an opportunity and physicians wishing to use the service are requested to complete specially prepared information sheets, which can be obtained from the CMS at 1601 East 19th Avenue, Denver, Colorado 80218, or by telephoning Sandy Wendt, at the Society, 861-1221, X267, or 1-800-332-4150, X267.

# book corner

*New books received are acknowledged in this section and such acknowledgment must be regarded as sufficient return for the courtesy of the sender. Selection will be made for review in the interests of our readers and as space permits. Books are listed with advance data supplied by publishers. Prices quoted are not guaranteed. For further information, address queries to the publishers. Books here listed are available for lending from the Denver Medical Society Library.*

## CARDIOVASCULAR SYSTEM

- Ambulatory Electrocardiography, Holter Monitor Electrocardiography.** New York, Springer-Verlag, 1979. 241 p. \$32.50.  
**Coronary-Prone Behavior.** Theodore M. Dembroski and others. New York, Springer-Verlag, 1978. 244 p. \$14.80.  
**Diagnosis and Therapy of Coronary Artery Disease:** Peter F. Cohn, ed. Boston, Little, Brown, 1979. 509 p. \$32.50.  
**ECG Arrhythmia Interpretation:** Harold A. Braun. Reston, Va., Reston Publishing, 1979. 312 p. Gift.  
**Exercise Electrocardiography:** Edward K. Chung, ed. Baltimore, Williams and Wilkins, 1979. 354 p. \$30.00.  
**Principles of Clinical Electrocardiography:** Mervin J. Goldman. 10th ed. Los Altos, Calif., Lange, 1979. 415 p. \$12.00.

## NERVOUS SYSTEM

- Current Practice of Clinical Electroencephalography:** Donald W. Klass and David D. Daly. New York, Raven Press, 1979. 532 p. \$37.00.  
**Facial Features of Neurologic Syndromes:** Paul R. Dyken. St. Louis, Mosby, 1980. 449 p.  
**The Human Nervous System; An Anatomic Viewpoint:** Murray L. Barr. 3rd ed. New York, Harper and Row, 1979. 339 p. \$15.95.  
**Management of Neurological Disorders:** Bryan Ashworth. Turnbridge Wells, England, Pitman Medical, 1977. 278 p. \$15.00.  
**Nervous System and Hypertension:** Philippe Meyer and Henri Schmitt, ed. New York, Wiley, 1979. 383 p. \$42.50.

## PSYCHIATRY

- Depression in Children and Adolescents:** Alfred P. French and Irving N. Berlin, ed. New York, Human Sciences Press, 1979. 298 p. \$18.95.  
**Group Psychotherapy:** Hugh Mullan. 2nd ed. New York, Macmillan, 1978. 418 p. \$17.95.  
**Hysterical Personality:** Mardi J. Horowitz. New York, Aronson, 1978. 441 p. \$17.50.  
**Massachusetts General Hospital Handbook of General Hospital Psychiatry:** Thomas P. Hackett and Ned H. Cassem, ed. St. Louis, Mosby, 1978. 593 p. \$14.95.  
**Outpatient Psychiatry:** Aaron Lazare, ed. Baltimore, Williams and Wilkins, 1979. 672 p. \$39.95.  
**The Psychopath:** William H. Reid, ed. New York, Brunner/Mazel, 1978. 348 p. \$17.50.  
**Psychosomatic Disorders in Childhood:** Melitta Sperling. New York, Jason Aronson, 1978. 415 p. \$20.00.  
**Recovery of Reality; Overcoming Chemical Dependency:** George A. Mann. New York, Harper and Row, 1979. 180 p. \$8.95.  
**Severe and Mild Depression:** Silvano Arieti. New York, Basic Books, Inc., 1978. 453 p. \$20.00.

## SURGERY

- Anesthesia for Infants and Children:** Robert M. Smith. 4th ed. St. Louis, Mosby, 1980. 702 p. \$25.00.  
**The Management of Trauma:** Walter F. Ballenger, ed. 3rd ed. Philadelphia, Saunders, 1979. 849 p. \$45.00.  
**Outpatient Surgery:** George J. Hill. 2nd ed. Philadelphia, Saunders, 1980. 1457 p. \$49.50.  
**Outpatient Surgery:** Richard C. Schultz. Philadelphia, Lea and Febiger, 1979. 470 p. \$48.50.

## GYNECOLOGY

- Manual of Gynecologic Endocrinology and Infertility:** Anne C. Wentz. Baltimore, Williams and Wilkins, 1979. 100 p. \$8.95.

## OBSTETRICS

- Maternal Recognition of Pregnancy:** Symposium on maternal recognition of pregnancy, London, 1978. New York Excerpta Medica, 1979. 425 p. Gift.

## PEDIATRICS

- Medical Care of the Sick Newborn:** Sophie Pierog. 2nd ed. St. Louis, Mosby, 1976. \$19.50.

## OPHTHALMOLOGY

- Symposium on Cataracts:** Symposium on cataracts, New Orleans, 1978. St. Louis, Mosby, 1979. 436 p. \$42.50.

## HOSPITALS AND OTHER HEALTH FACILITIES

- Emergency Department Organization and Management:** Astor L. Jenkins, ed. 2nd ed. St. Louis, Mosby, 1978. 333 p. \$21.50.  
**Hospital Law Manual, Attorney's Volume.** Germantown, Md., Aspen Systems Health Law Center, 1979. 3 v. \$195.00.  
**Planning Guide for Physicians' Medical Facilities:** American Medical Association. 3rd ed. Chicago, AMA, 1979. 39 p. \$3.00.  
**Prospective Rate Setting:** William L. Dowling. Germantown, Md., Aspen, 1977. 159 p. Gift.

## Two Component Societies Join Communications Effort

The Denver Medical Society and the Clear Creek Valley Medical Society have entered into a joint endeavor in cooperation with KLAK and its FM affiliate, KPPL, to present a radio program "Speaking of Medicine" in the Denver area. Each society is providing a half-hour program, alternating on Sunday nights at 10:30 p.m. Programs began on March 2 and a commitment has been made for 26 weeks.

Some of the early subjects covered are Medical Indigency, Family Practice, Home Health Care, Child Abuse and Mental Health. The recording is being done with the help of the CMS Communications Department, and completed cassettes are delivered to the radio station by the societies.

Another communications effort being undertaken by the Denver Medical Society is a feature column in The Denver Post. Plans for such a column have been under discussion with The Denver Post for an extended period of time. The Society has arranged for the assistance of Mr. Herb Stoenner, well-known Denver Post staff writer who is now semi-retired, to assist in the preparation of the columns for publication.

This series of columns will provide a forum for the Society to discuss many of the medical issues being given current press coverage, and to express its views about health matters and the future of health care. The frequency of the columns has not been determined at this time.



# The Workings of MEDLINE

Accidentally or intentionally, barbiturates have been swallowed with a gulp of wine. Death has resulted, but what was the interaction of the synergistic combination? The specifics of the chemical interaction need to be established at post-mortem.

What does the doctor do?

Wisdom and familiarity should lead him to call the Denver Medical Society Library, and in consultation with its reference librarian Martha Burroughs to use MEDLINE. Within ten minutes, this on-line system turns up the needed references to resolve this medical crisis.

Or a physician is asked to testify in court in a child-abuse case, needing to respond to questions regarding the determination of the exact cause of a bruise on a child.

Again, MEDLINE, a computerized literature retrieval service, directly linked to the National Library of Medicine at Bethesda, serves as the data base.

Determination of MEDLINE use lies largely in the area of patient care, but there is, as well, much usage by doctors preparing papers for delivery and publication. MEDLINE is both tool and method, using a controlled vocabulary which draws on materials gathered during the past two years - 1978 and 1979 to date.

Another distinct program, also a computerized literature retrieval service, drawing on a comparable data base, is TOXLINE which gathers together information indexed since 1974 regarding toxicity in both humans and animals. It functions out of a natural language data base, with Keywords established to select materials.

Actually, the question regarding the barbiturates and liquor was posed to both MEDLINE and TOXLINE, and it was the latter service which provided the essential information.

MEDLINE is a computerized version of the Index Medicus, standard reference guide to medical articles, published since 1879. The entire system with its multiple elements is called MEDLARS, a registered acronym for Medical Literature Analysis and Retrieval System.

Martha Burroughs is responsible for running these searches. She is computer-trained, and runs a keyboard in the library which is connected by telephone to IBM 370-158 computers at the National Library of Medicine at Bethesda, where the simple requests are received and materials gathered for response.

The Boolean system in use means that basically, logical operators are utilized to combine search terms according to the logic of Boolean algebra, and they can best be explained by means of sample search statements.

This might mean that a search for information on allergic reactions to IV glucose would commence with the statement "corn or glucose," suggesting that corn in the solution may be creating an allergic reaction.

A second statement would be "I and Hypersensitivity," the latter the preferred term for allergy.

In the course of the numerous demonstrations that Martha has presented, a number of matters have been stressed.

It is interesting that the computer with which Martha is connecting is located not in Denver or Boulder but in Bethesda, Maryland, at the National Library of Medicine.

The speed of response is vital to those seeking information. On-line portions of the data base are answered completely, within ten minutes, or less.

CRT or Cathode Ray Tube screens are used at demonstrations but not in actual usage. The original is typed by computer input and mailed or picked up by the ordering doctor.

Those online responses contain a limit of 30 references, and the balance would be mailed to the DMS Library for relaying on to the ordering doctor.

Allen Young  
Assistant Editor

## AMA Plans CME Meeting for San Francisco

The American Medical Association has organized a series of fifteen Continuing Medical Education courses, designed expressly for the clinician, which will take place on Friday through Sunday, June 13 through 15 at the Hyatt Union Square, San Francisco.

Co-sponsored by the University of California at San Francisco School of Medicine and the California Medical Association, it will present courses in depth in fields of general significance with a stress on the specialty and the depth. These courses will meet the criteria for Category I on an hour-for-hour basis for the Physicians Recognition Award of the AMA.

For further information write The Continuing Medical Education Group, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

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# council on legislation

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Weekly meetings continue as amended bills are reviewed and plans are being made for the legislative seminar in Vail at the end of May. CMS staff assigned to other councils have been attending the meetings, as has the specialty societies' staff person. This is an attempt to better coordinate the lobbying efforts.

The relationship between COMPAC and the Council on Legislation has been discussed, and assembled voting records will be an important part of COMPAC decisions.

Careful records were kept on votes in the House of Representatives concerning the addition of chiropractors, optometrists, and podiatrists to the medically indigent insurance bills. Keymen were notified and said the "thank you" or the "why?"

## LEGISLATIVE UPDATE

*Air Pollution:* Four of the original eight auto emissions control bills remain alive with some combination necessary if Colorado is to comply with federal regulations. The legislature recessed for one week in mid-March while several ad hoc committees worked on specific bills that were lagging behind the rest of the legislative process. Air pollution was one of those.

*Arthritis:* The bill establishing an arthritis educational outreach program under the health department and providing for a fellowship in rheumatic diseases at the medical school was killed on the House floor on February 21st.

*Certificate of Need:* Both certificate of need bills are moving through the Senate, having been passed by the House. Colorado Medical Society has amended them in order to answer some fears.

*Child Abuse:* The six child abuse bills continue to move and are supported by CMS.

*Medically Indigent Insurance:* The four bills addressing this subject remain alive but are rewritten regularly. The health insurance industry opposes parts of them; the uncertainty of the price tag frightens many; a pilot program begins to look appealing.

*Physician Salaries:* The bill increasing the maximum salaries of physicians in the state personnel system remains alive and well. The maximum would be \$64,450.

The status of legislation regarding *Cost Containment*, *Emergency Medicine*, the *Nurse Practice Bill*, and *Parking for Handicapped* remains unchanged since the March report.

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## New CMS Service for Members: File for CME Records

As a service to members, the Council on Professional Education of the Colorado Medical Society will soon be distributing a personal continuing medical education record file to help physicians keep track of their CME hours. This will aid at relicensure time and in applying for the American Medical Association's Physician's Recognition Awards.

The personal file will consist of two manila folders stitched together, tabbed for easy access in a standard file drawer, printed with basic, important CME information. The file will serve as a reminder of the Board of Medical Examiners new requirements regarding CME; the file will have pockets for saving certificates of attendance of CME programs;

the file will come with padded attendance forms that need only be filled in and dropped into the applicable pocket. Finally, the file will have a section for saving information concerning up-coming CME events or other general information. At the end of the year, the physician will simply use the accumulated record sheets to complete the license renewal form.

The file folders will be distributed approximately May 1st, in a special mailing to all Colorado Medical Society members. This method of yearly tabulation has been used in other applications for relicensure, and has been found most helpful. Watch for the file to be sent to your office.



# Colorado Medical Society

## HOUSE OF DELEGATES ACTIONS

### INTERIM SESSION

February 29 — March 2, 1980

.....The House of Delegates held two meetings during the 1980 Winter Clinics. Actions resulting from those meetings are outlined below. If any member of the Society has additional questions about any action, he should feel free to contact the state Society Executive Office which maintains a complete Handbook of actions as approved by the House. This condensed transcript will serve as the official publication of the Actions of the House. We urge each member to attend component society meetings at which time these Actions are scheduled to be reviewed. Copies of reports and resolutions as adopted are available from the state Society upon request.

.....Speaker, Richard Bedell, M.D., called the House to order at 9:00 a.m., February 29. The Rabbi Earl Stone delivered the invocation. President Ray Witham led the House in the Pledge of Allegiance to the Flag. The Chairman of the Committee on Constitution, By-Laws and Credentials announced that a quorum was present and the Speaker declared the House was ready for business. The minutes of the 1979 Annual Session were approved as printed in the October issue of COLORADO MEDICINE. Attendance at the first meeting of the House on February 29 was recorded at 139.

.....Speaker Bedell announced the House would operate under the Sturgis Standard Code of Parliamentary Procedures. Dr. Joseph Kovarik served as Parliamentarian.

.....Dr. Ray Witham, President, addressed the House. (Dr. Witham's remarks were referred to the Reference Committee on Board of Trustees and Executive Office except for Page 3, Lines 1-24, which was referred to the Reference Committee on Scientific Education.)

.....The House heard remarks from Governor Richard Lamm; Mr. R. G. Bowman, Executive Vice President of CMS; Senator Harvey Phelps (referred to Reference Committee on Legislation); Mrs. Betsy Becker, President of the Colorado Medical Society Auxiliary; and Mrs. Lynn Painter, CMS Auxiliary Health Power Project Chairman.

.....The House received the following late reports and referred them to the Reference Committee indicated: LM/BT-2 and Addenda 1 and 2 - Colorado Medical Society Policy Regarding Physician's Assistants (Referred to Reference Committee on Interprofessional Relations); LM/BT-3 - Supplemental Report (Referred to Reference Committee on Board of Trustees and Executive Office); LM/EVP-1 - Progress Report, Executive Vice President (Referred to Reference Committee on Board of Trustees and Executive Office); L/L-2 - Supplemental Report, Council on Legislation and Addendum 1 (Referred to Reference Committee on Legislation); LM/MS-2 and Addenda 1, 2, and 3 - Progress Report of Emergency Medical Care Committee Hospital Emergency Department Categorization (Referred to Reference Committee on Medical Service.)

.....Accepted the following late resolutions and referred them to the Reference Committee indicated: LM/RES-6 - Statement and Recommendations Regarding Care of Medically Indigent Maternal and Newborn Patients (Reference Committee on Socio-Economics); LM/RES-7 - Testimony and Representation by Special Committee for Negotiations (Reference Committee on Board of Trustees and Executive Office); L/RES-9 - Hartford's Premium Scale for Part-time Physicians (Reference Committee on Board of Trustees and Executive Office); L/RES-10 - Immunity of Component Society Grievance Committees (Reference Committee on Board of Trustees and Executive Office).

.....Referred HB/RES-1 - Alternating Place of Annual Session - to the Nominating Committee.

.....LM/RES-8 - COMPAC Support by the Colorado Medical Society - was withdrawn.

.....Elected to the Nominating Committee: District I - Robert Hartley, M.D., Weld; District II - Anthony Palmieri, M.D., Adams County-Aurora; Frank Sargent, M.D., Arapahoe; Alan Stormo, M.D., Boulder; Stanley Sontag, M.D., Clear Creek Valley; Edward Rhodes, M.D., Denver; District III - Joseph Pollard, M.D., El Paso; District IV - Robert Dingle, M.D., Pueblo; District V - Kenneth Nelson, M.D., Mesa.

.....Attendance at the second meeting of the House was recorded at 140.

## REFERENCE COMMITTEE ON BOARD OF TRUSTEES AND EXECUTIVE OFFICE

.....HB/BT-1 - Progress Report, Board of Trustees was approved with an amendment on Page 2, deleting the sentence on lines 39-40, substituting it with, "Both bodies will continue the function of accrediting inter and intra state CME programs." Report contains a digest of actions taken by the Board of Trustees since the Annual Session as well as a report on the activities of the Public Information Committee, Professional Liability Review Committee and Committee on Physician Health and Rehabilitation.

.....LM/BT-3 - Supplemental Report, Board of Trustees was approved. Contains a report on the activities of the Risk Management Committee, Special Committee for Negotiations and Task Force to Study Grievance Mechanism.

.....LM/EVP-1 - Progress Report, Executive Vice President was filed. Notes that the Rocky Mountain Medical Journal was discontinued in December and Colorado Medicine was inaugurated as a magazine of medical information, news and clinical briefs. Reports on staff activities in addition to some positions taken by the Board of Trustees regarding Board/staff relationships, Western Physicians Purchasing Association, membership, financial situation of the Society and the Professional Liability Insurance Program.

.....HB/JC-1 - Progress Report, Judicial Council and HB/GC-1 - Progress Report, Grievance Committee were approved with the recommendation that the Constitution, By-Laws and Credentials Committee, in concert with the Organizational Study Committee, review Colorado Medical Society's By-Laws and recommend any necessary changes at the Annual Session in 1980 relating to organizational structure and duties and responsibilities of all administrative components of the Colorado Medical Society, most specifically administrative councils, committees and the Board of Trustees, as well as the House of Delegates.



.....HB/AMA-1 - Report of the 1979 AMA Clinical Meeting was filed. Report contains a summary of the major actions taken by the AMA House of Delegates at its Interim Meeting in Hawaii.

.....HB/FA-1 - Progress Report, Colorado Medical Foundation was filed.

.....HB/HIST-1 - Progress Report, Historian was filed. Reports on continuing efforts of the Archives Committee in the area of record retention.

.....HB/RES-5 - SCHEDULING OF MEETINGS was not adopted. The House recommended that leadership and staff continue attempts to avoid any conflict of scheduling Board of Trustees and administrative council meetings with scheduled meetings of component societies.

.....LM/RES-7 - TESTIMONY AND REPRESENTATION BY SPECIAL COMMITTEE FOR NEGOTIATIONS was adopted as amended. Lines 10 through 12, 14 through 18 and 22 through 23 were deleted.

RESOLVED, that the Special Committee for Negotiations represent all segments of the Colorado Medical Society fairly and without prejudice.

.....Substitute Resolution 9-A - HARTFORD'S PREMIUM SCALE FOR PART-TIME PHYSICIANS was adopted.

RESOLVED, that the matter be referred to the Risk Management Committee of the Colorado Medical Society:

- (1) for further study of the actuarial facts dictating this policy;
- (2) for recommendations, if any, for solution to the problem presented, and
- (3) for a report as a part of the annual Risk Management Committee report at the Annual Session in 1980.

.....Substitute Resolution 10-A - IMMUNITY OF COMPONENT SOCIETY GRIEVANCE COMMITTEES was adopted.

RESOLVED, that the House of Delegates direct the Board of Trustees to investigate and carry out the most appropriate means to secure adequate immunity for grievance committees of the component societies of the Colorado Medical Society.

.....Report to the House of Delegates, Ray G. Witham, M.D., President, was filed, (except for Page 3, Lines 1-24 referred to Reference Committee on Scientific Education).

## REFERENCE COMMITTEE ON INTERPROFESSIONAL RELATIONS

.....LM/BT-2 - Colorado Medical Society Policy Regarding Physician's Assistants and Addendum No. 1 - Guidelines for Physicians Employing Physician's Assistants, and Addendum No. 2 - Rules and Regulations Pertaining to the Supervision and Direction of Non-physician Health Care Providers were approved with amendments to Addendum No. 2.

The amendments to Addendum No. 2 are as follows:

On Page 5, Section d., the following deletions and additions were made:

d. The licensed physician must provide adequate supervision ~~of-the performance-of-delegated-medical-services-~~ AS DEFINED IN THE 1975 COLORADO MEDICAL SOCIETY GUIDELINES FOR PHYSICIANS EMPLOYING PHYSICIAN'S ASSISTANTS (LM/BT-2, Addendum No. 1, Page 1, No. 5).

"SUPERVISION - RELATES TO THE DEGREE OF PERSONAL GUIDANCE PROVIDED BY THE RESPONSIBLE PHYSICIAN. THE MEDICAL PRACTICE ACT STATES: 'THE RENDERING OF SERVICES UNDER THE PERSONAL AND RESPONSIBLE DIRECTION AND SUPERVISION OF A PERSON LICENSED UNDER THE LAWS OF THIS STATE TO PRACTICE MEDICINE' SHALL NOT BE CONSIDERED THE PRACTICE OF MEDICINE.

"A. DIRECT SUPERVISION - THE EMPLOYING OR RESPONSIBLE PHYSICIAN MUST BE AVAILABLE TO HIS ASSISTANT IN PERSON OR WITHIN THE SAME OFFICE OR HOSPITAL. THIS IMPLIES ONGOING COMMUNICATIONS BETWEEN THE PHYSICIAN'S ASSISTANT AND THE PHYSICIAN.

"B. INDIRECT SUPERVISION - THE EMPLOYING OR RESPONSIBLE PHYSICIAN, ALTHOUGH NOT IMMEDIATELY AVAILABLE TO THE ASSISTANT, MUST HAVE A PRE-ARRANGED PLAN OF ACTIVITY OR TREATMENT FOR THE SPECIFIC PATIENT PROBLEM WHICH THE ASSISTANT MAY CARRY OUT IN THE ABSENCE OF ANY COMPLICATING FEATURES AND BE IMMEDIATELY AVAILABLE BY TELEPHONE OR OTHER ELECTRONIC MEANS.

"IF THE EMPLOYING OR RESPONSIBLE PHYSICIAN IS UNABLE TO DIRECTLY OR INDIRECTLY SUPERVISE THE ACTIVITIES OF HIS ASSISTANT, HE MUST MAKE ARRANGEMENTS FOR ANOTHER PRIMARY-CARE PHYSICIAN OF APPROPRIATE TRAINING TO ASSUME THE RESPONSIBILITY FOR THIS SUPERVISION OR TEMPORARILY SUSPEND THE PRACTICE ACTIVITIES OF HIS ASSISTANT.

"TO QUALIFY AS A PROPER SUBSTITUTE, THE PHYSICIAN MUST BE FAMILIAR WITH THESE GUIDELINES AND WITH THE TRAINING, CAPABILITIES, AND LIMITATIONS OF THE PARTICULAR PHYSICIAN'S ASSISTANT AND BE WILLING TO ASSUME ETHICAL AND LEGAL RESPONSIBILITY FOR DIRECTION OF THE ASSISTANT'S ACTIVITIES AND CARE OF THE PATIENTS HE SEES." Supervision is intended to assure that the directions given are carried out properly. ~~Supervision may include constant over-the-shoulder inspection-of-the-performance-of-the-medical-services;-after-the-fact-review through-viewing-the-patient-or-his-chart-or-conferring-with-the-non-physician health-care-provider-rendering-the-delegated-medical-services-~~ "In determining whether such supervision is adequate, under the circumstances of each case, the licensed physician and the Board shall consider the following factors: ...."

On Page 6, the final sentence of Section d. was amended as follows:

"Finally, the licensed physician must review the quality of medical services rendered IN REMOTE SITES by such non-physician health care providers by over-the-shoulder, on-site inspection AND COUNTERSIGNATURE OF THE NON-PHYSICIAN HEALTH CARE PROVIDER'S NOTES at intervals of no longer than seven days AND DAILY IF POSSIBLE to assure compliance with the licensed physician's directions."

On Page 6, Section e., Item 1 a. was amended as follows:

"(a) each and every prescription and refill shall be entered on the patient's chart and countersigned by the supervising physician within one week AND WITH DAILY SUPERVISION IF POSSIBLE. The pharmacy providing the medication should be identified if possible."



The recommendation to amend Page 7, Section e., Item 1 d. was defeated.

The House referred to the Board of Trustees for appropriate action the recommendation that future Colorado Medical Society policy be to continue developing a program towards definition or certification of physician's assistants (P.A.) according to the qualifications of a generic P.A. defined in Addendum No. 1, Page 1.

.....HB/IPR-1 - Progress Report, Council Interprofessional Relations and Addendum No. 1 - Letter to Hearing Clerk, Food and Drug Administration, and Addendum No. 2 - Goals and Objectives of Council on Interprofessional Relations were approved. The House approved a recommendation that a letter of appreciation be sent to U.S. Representative Patricia Schroeder for her interest in the Drug Reform Act of 1979. Report summarizes activities of the Council -- future emphasis of the Council should be development of a more meaningful liaison with other voluntary organizations

## REFERENCE COMMITTEE ON LEGISLATION

.....HB/L-1 - Progress Report, Council on Legislation was approved. Report summarizes the Council's activities. Emphasis is being placed on communication with the membership and providing information about the importance of their political involvement at all levels of government; this effort is evidenced by broadening the KeyMan program to include contact persons for health related boards and committees; a legislative seminar for state lawmakers and CMS membership; opportunities for component societies to spend a day at the capitol during the 1980 session and meet their senators and representatives; and presentations by Council members and staff at component society meetings.

.....HB/L-1, Addendum No. 1 - Priorities Regarding CMS Goals and Objectives was approved with the recommendation that Priority #7 be deleted on the basis that it was not an appropriate activity for the Council on Legislation. A recommendation to refer Priority #6 back to the Council on Legislation for revision was defeated.

.....L/L-2 - Supplemental Report, Council on Legislation was approved. Council encourages the membership to use the Legislative Hotline to keep abreast of current legislation being followed by the Council on Legislation.

.....L/L-2 - CMS Legislative Report was approved.

.....HB/RES-2 - RECOMMENDATION REGARDING SALARY FOR PHYSICIANS EMPLOYED BY THE STATE OF COLORADO was adopted.

RESOLVED, that the Colorado Medical Society support legislation which changes the 1972 ceiling on salaries for physicians employed by the State of Colorado from \$38,724.00 to an amount not to exceed \$64,464.00, in compliance with the current recommendation of the Colorado State Department of Personnel.

.....Address of Senator Harvey W. Phelps was filed.

## REFERENCE COMMITTEE ON MEDICAL SERVICE

.....HB/MS-1 - Progress Report, Council on Medical Service was approved. Report contains a digest of Council and Committee activities. Notes the Committee on Medical Manpower's involvement in the Manpower Consortium and the recommendation that partial financial support for this Consortium be placed in high priority for the next fiscal year in the Society's budget, and that staff in-kind activity will be important in the area of public relations; the committee has also begun working on a brochure on behalf of the Society for rural physician recruitment; methods of improving specialty consultation in rural areas of Colorado has also been discussed by the committee. The Committee on Medical Care in Correctional Institutions reports that the Board of Trustees approved the Society's participation in the American Medical Association/Law Enforcement Assistance Association Jail Project Grant. The Rural Health Committee reports that it is working toward the development of a Model Rural Family Practice Clinic in Glenwood Springs.

.....LM/MS-2 - Progress Report of Emergency Medical Care Committee Hospital Emergency Department Categorization was filed.

.....LM/MS-2, Addendum No. 1 - Emergency Department Categorization Report was filed with the following changes: On page 17, the sentence beginning on line 37 through line 39 was deleted, "The presence of a separate Kaiser emergency facility with inadequate equipment and staff should be discouraged."

A recommendation to include the definition of "resource hospital" from the Council on Medical Service was approved.

The Reference Committee's recommendation to delete the sentence beginning on line 41 through 43, page 11B, was defeated.

.....LM/MS-2 - Addendum No. 2 - Criteria Used By Categorization Team was filed.

.....LM/MS-2 - Addendum No. 3 - Proposed Criteria for Cardiac Emergencies, Emergency Services and General Trauma was approved.

## REFERENCE COMMITTEE ON PUBLIC HEALTH

.....HB/PH-1 - Progress Report, Council on Public Health was approved with the recommendation that the Council Chairman contact the chairmen of inactive committees to see if they would be willing to continue their efforts, and serious thought be given by Colorado Medical Society officers and the Council to delete, combine or initiate new committees to better meet the issues of Colorado Medical Society in the 80's. Report contains a summary of Council and Committee activities. The Council continues to monitor bills before the state legislature concerning the safe transport, storage and disposal of hazardous waste. Council will be addressing projects under Priority #1, Objective II, Health Improvement.

## REFERENCE COMMITTEE ON SCIENTIFIC EDUCATION

.....HB/PR.ED.-1 - Progress Report, Council on Professional Education was approved with the deletion of all underscored lines 7 through 10 on page 1 and deletion of lines 20 through 22, page 2, substituting the following sentence for both: "Investigate current and projected applications of electronic data processing



based information and communications systems and sponsor programs to educate Colorado physicians in the understanding of the applications of these systems." The report addresses Council activities in relation to continuing education, also includes a review of the Corporate Goals and Objectives pertaining to the Council. The House approved a recommendation contained in the report asking that the Standing Rule of the House of Delegates on "Reference Committees" be amended so that the Reference Committee on Scientific Education becomes the Reference Committee on Professional Education to conform with the By-Law amendment in September 1979, changing the name of the Council on Scientific Education to the Council on Professional Education.

## REFERENCE COMMITTEE ON SOCIO — ECONOMICS

.....HB/SOC.EC.-1 - Progress Report, Council on Socio-Economics was approved with the following amendments: On Page 1, the sentence beginning on Line 36 through 39 was deleted in view of the fact the creation of a "physician pool" was a suggestion by the Committee on Private Health Insurance rather than the Council on Socio-Economics. The House suggested that the Council conduct further studies in this area. On Page 4, Line 47, the words "Colorado Hospital Commission" were deleted and the words "Voluntary Effort" were substituted. Council reports that several important issues under its jurisdiction are being addressed by specific committees. The Committee on National/Catastrophic Health Insurance has focused its attention on proposed health care financing options for Colorado. The Government Health Planning Committee notes that the committee must be re-structured to better monitor and lead the Health System Agencies (HSAs), State Health Coordinating Council (SHCC), and State Health Planning and Development Agency (SHPDA). A Committee on HMO/IPA was organized on an ad hoc basis to deal primarily with specific inquiries of an informational nature regarding health maintenance organizations. The Council continues to develop and present practice management programs to the membership. Anticipated activities of the Council and its Committees include studying the development of a physician arbitration pool, a long term study of the Choicecare demise may be undertaken, and finally, a shared financing arrangement between the Colorado Medical Society and component societies is being proposed to fund staff to monitor each HSA.

.....Adopted Substitute Resolution 3-A - PHYSICIAN PARTICIPATION IN MEDICAID PROGRAM.

RESOLVED, that the Colorado Medical Society will strive to assist such disadvantaged citizens through both the private and public sectors, and be it further

RESOLVED, that the Colorado Medical Society volunteer its participation to work with the Colorado Department of Social Services in a creative fashion to effect significant improvements in the Medicaid program, thereby encouraging increased physician participation.

.....Adopted Substitute Resolution 4-A - COLORADO HOSPITAL COMMISSION.

RESOLVED, that the Colorado Medical Society go on record as continuing to support voluntary efforts as the most desirable mechanism for attempting to control rising hospital costs.

.....LM/RES-6 - STATEMENT AND RECOMMENDATIONS REGARDING CARE OF MEDICALLY INDIGENT MATERNAL AND NEWBORN PATIENTS was postponed definitely until the 1980 Annual Session. Although the intent of the resolution was strongly supported, it was felt that action should be postponed because of legislation now being

considered dealing with both short and long term solutions to the problems of providing health care to the medically indigent.

## REFERENCE COMMITTEE ON CONSTITUTION, BY LAWS AND CREDENTIALS

.....HB/OSC-1 - Progress Report, Organizational Study Committee was approved. Reports that the Committee has considered the amended Standing Rules of the House, "Honorarium of President" and agreed that the Organizational Study Committee should designate a specific stipend early in advance of nomination and selection of the President and President-elect, subject to final decision of the Board of Trustees in reference to prevailing economic factors; further discussions will take place. Report also reviews the Corporate Goals and objectives relating to the Organizational Study Committee.

## OTHER ACTIONS TAKEN AT THE INTERIM SESSION

.....Adopted HB/RES-1 - ALTERNATING PLACE OF ANNUAL SESSION.

RESOLVED, that the House of Delegates amend its previous actions and approve holding future Annual Sessions alternately at The Broadmoor and at Keystone beginning with the 1981 Annual Session; this action to be reviewed in 1985.

.....Elected to Honorary Membership M. Roy Schwarz, M.D., Dean of the University of Colorado School of Medicine, and Lawrence M. Wood, Legal Counsel.

.....The House was adjourned Sunday, March 2, 1980, without day.

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Plan now to attend the Annual Session at The Broadmoor, September 24-27, 1980. The House of Delegates will meet September 24, with Reference Committees that same afternoon.

Any resolution requiring additional finances and/or a change in the dues structure necessitating a vote of membership must be in the hands of the executive office 75 days prior to the meeting of the House of Delegates (July 11, 1980) and in the hands of the component societies 60 days prior to such meeting.

All reports of Officers, Boards, Councils and committees reporting to the House and all resolutions must be in the executive office 45 days before the Annual Session opens (August 8, 1980).

NOTE: PLEASE KEEP THE BOOKLET, "PROCEDURES OF THE HOUSE OF DELEGATES" DISTRIBUTED AT THE INTERIM SESSION AND BRING IT WITH YOU TO THE ANNUAL SESSION. A SPECIAL THANKS TO DR. RICHARD BEDELL FOR HIS TIME AND EFFORT IN PREPARING THIS PUBLICATION.



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# board of trustees condensed minutes

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1. Approved the minutes of the Board of Trustees meeting of February 28, 1980.
2. (A) Received the report of Ray G. Witham, M.D., President, which included background information on the Motorcycle Helmet Law; the Auxiliary Project - "Health Power"; an official visitation from the Japan Medical Society; update on meeting with representatives of CUPS; notification that tapes are available from the AMA Leadership Conference; and action taken by CFMC Board concerning Ambulatory Surgery.
- (B) Approved the report of the Finance Committee, the Financial Statements and the Check Register.

Approved motion for Board of Trustees to support conceptually the Motorcycle Helmet Law in an amount up to \$5,000 in the form of forming a separate organization (coalition with other groups).

Discussed travel reimbursement policy and referred the matter to the Organizational Study Committee to work with staff and return policy to the Board.

Approved additional allocation of \$2,000 to the "Health Power" project of the Auxiliary.

Disapproved support of printing costs of brochure by DMS concerning allied health professionals.

Heard presentation for a statewide collections system by representatives from I.C. Systems, Inc. Referred back to the Finance Department and to the Legal Counsel with request it be returned to the Finance Committee and to the Board of Trustees.

(C) Council Reports:

Approved actions of the Council on Legislation as follows:

SB-105	Nurse Practice Legislation	Support
HB-1092	concerning tax exemptions for prescription devices	Oppose
HB-1162	concerning Colorado Certificate for Public Necessity	Watch
HB-1226	State Health Insurance Plan	Support

Recommended that a list of physicians not be provided to legislators.

Approved actions of the Council on Professional Education for CMS to cease notifying LCCME of accrediting actions, and to accept, without objection, recognition of LCCME credits by the Colorado State Board of Medical Examiners.

Approved recommendation of HMO/IPA Committee that CMS not engage in an independent study of ChoiceCare and requested Executive Vice President to have staff compile file, retrospectively and prospectively, concerning ChoiceCare.

3. Accepted comments and suggestions submitted by the Speaker of the House and referred them to the Organizational Study Committee for consideration with request to submit these comments with the OSC recommendations to the Board of Trustees for subsequent approval.
4. Reviewed the actions of the House of Delegates with specific attention to policy regarding Physician's Assistants. The amendments adopted by the House of Delegates will become part of CMS policy; appropriate agencies will be notified; the Council on Interprofessional Relations will be requested to monitor changes.

Referred Substitute Resolution 10-A "Immunity of Component Society Grievance Committees" to the Organizational Study Committee for necessary By-Law provision.

5. Received report of Executive Vice President. Actions include: (a) CMS will no longer participate in Western Physicians Purchasing Association in any manner; (b) Request CMS staff to present demonstration project to Board on the computerized placement services for physicians; (c) Approved mailing highlights of Board of Trustees minutes to Board members, component society presidents, etc., immediately following the Board of Trustees meetings (48 hours), with full minutes being mailed to Board members with the agenda materials for the following meeting; (d) Received new CMS staffing assignments.
6. President-elect announced tentative schedule for Planning Session in mid-October.

Adopted jointly with the CFMC Board to support the concept of ambulatory surgery, recognizing that there are many communities in the State of Colorado where the concept cannot function. Consequently, the position taken is to encourage physicians to perform 51 surgical procedures on an ambulatory basis where the resources for ambulatory surgery are available.

Recommended publication of position on ambulatory surgery in Colorado Medicine, and further, that the Executive Committees of CMS and CFMC meet to prepare a public statement.

Requested Risk Management and Professional Liability Review Committees to present in writing a suggested list of problems for intensive review.

Following a brief update on the negotiations with The Hartford, the Board authorized the Executive Committee to select a candidate or candidates to pursue the feasibility study authorized at the last meeting of the Board.

7. Established April 18 as the date of the next meeting of the Board of Trustees.



## MEMBERS PRESENT:

President - Ray G. Witham, M.D.  
President-elect - K. Mason Howard, M.D.  
District I - David E. Bates, M.D.  
District II - Jerry J. Appelbaum, M.D., Abraham J. Kauvar, M.D.  
Frederick A. Lewis, Jr., M.D., Philip H. Norton, M.D.  
Joseph H. Poynter, M.D., Wilfred Stedman, M.D.  
District III - Amilu S. Martin, M.D.  
District IV - Jan S. Hildebrand, M.D.  
District V - Telford A. Davis, M.D.  
R. G. Bowman, Executive Vice President - Ex officio, non-voting

## MEMBERS ABSENT:

## EXCUSED

District I - Merlin G. Otteman, M.D.  
District II - William E. Jobe, M.D.  
District III - J. Richard Brusenhan, M.D.  
District IV - Hanns C. Schwyzer, M.D.  
District V - Robert F. Linnemeyer, M.D.

## DELEGATE ATTENDANCE - 1980 INTERIM SESSION

### DISTRICT I - 16 DELEGATES

#### Larimer - 7 Delegates

(D) Cronin, John C. (1)  
(D) Miller, Burdette L. (1-2)  
\*(A) Allen, Thomas J. (1-2)  
(D) Standard, Peter J. (1-2)  
(D) Baumgartel, Earl D. (1)  
(D) Bruns, Thomas N. C. (1)  
(D) Merkel, Lawrence A. (2)

#### Morgan - 1 Delegate

(D) Thompson, Patrick L. (1-2)

#### Northeast Colorado - 1 Delegate

(D) Ollhoff, Harold J. (1-2)

#### Washington-Yuma - 1 Delegate

None Present

#### Weld - 6 Delegates

(D) Clifford, Nathan J. (1)  
(D) Hartley, Robert D. (2)  
(A) Hutchins, Earl C. (2)  
(D) Bagley, David L. (1-2)  
(D) Baldwin, Thomas E. (1-2)

### DISTRICT II - 113 DELEGATES

#### Adams County-Aurora - 7 Delegates

(D) Greenholz, Daniel J. (1-2)  
(D) Martin, William M. (1-2)  
(D) Palmieri, Anthony J. (1)  
(D) Delaney, James J. (1-2)  
(A) Hopple, Lynwood M. (2)  
(D) Heaton, C. Edward (1-2)  
(D) Kopelman, J. Joshua (1)  
(A) Jacobs, Herbert L. (2)  
(D) MacPhee, William M. (1)  
(A) O'Dell, Robert A. (2)

#### Arapahoe - 13 Delegates

(D) Feiler, Ernest M. (1-2)  
(D) Freed, John H. (1-2)  
(A) Simon, John, Jr. (1)

(D) Heller, Arthur P. (2)  
(D) Milligan, Gatewood C. (1-2)  
(D) Sargent, Frank T. (1-2)  
(D) Knize, David M. (1-2)  
(D) Kreye, George M. (1-2)  
(D) Seegers, Winnifred (1-2)  
(A) Blease, Ernest B., Jr. (1-2)  
(D) Steines, William J. (2)  
(D) Thompson, Richard H., Jr. (1-2)  
(D) Wood, John M. (1)

#### Boulder - 11 Delegates

(D) Avery, John S. (1)  
(D) Marcotte, Dale D. (1-2)  
(D) Rubright, Marcus W. (1-2)  
(A) Morrison, John T. (2)  
(D) Strenge, Henry B. (1-2)  
(D) Wilson, Don E. (1-2)  
(D) Baumgardner, Jan F. (1-2)  
(D) Becher, Harold T. (1-2)  
(A) Kroger, J. Stephen (1-2)  
(D) Stormo, Alan C. (1-2)  
(D) Kelley, Severance B. (1-2)

#### Clear Creek Valley - 19 Delegates

(D) Campbell, Bernard E. (1-2)  
(A) Walters, Vernon W. (1)  
(D) Doig, William L. (1-2)  
(D) Doyle, Herman E. (1-2)  
(A) Tegtmeier, Ronald E. (1-2)  
(D) Golbert, Thomas M. (1-2)  
(D) McCreedy, Gordon J. (1)  
(D) Ritzman, Vernon D. (1-2)  
(A) Brundige, Ralph E. (1)  
(D) Sontag, Stanley J. (1-2)  
(D) Karlin, Joel M. (1-2)  
(D) Weston, Eugene L. (2)  
(A) Selby, Robert L. (1-2)  
(A) Tarkanian, Malcolm A. (2)  
(D) Stevens, Wayne E. (1-2)  
(A) Conner, Wayne L. (2)  
(D) Oppenheim, Walter H. (1-2)  
(D) Markel, William R. (1)

(D) Silverberg, Stuart O. (1-2)  
(D) Ford, John J., III (1-2)  
(D) Call, William H. (1-2)

#### Denver - 60 Delegates

(D) Aikawa, Jerry K. (1-2)  
\*(A) Parsons, Donald (1-2)  
(D) Boyd, Harry R. (1)  
(D) Bramley, Howard F. (1-2)  
(D) Butterfield, L. Joseph (1-2)  
(D) Cook, William R. (1-2)  
(A) Campbell, William A., III (2)  
(D) Harvey, Duval E. (1)  
(D) Hoch, Peter C. (1-2)  
(D) Jennings, R. Lee (1-2)  
(D) Klapper, Jack A. (1-2)  
(D) Kovarik, Joseph L. (1-2)  
(D) Lowry, Hope (1-2)  
(D) Miller, Edward S. (1-2)  
(D) Peck, Mordant E. (2)  
(D) Philpott, Osgoode, S., Jr. (1-2)  
(A) Nelson, Nancy E. (1-2)  
(D) Rhodes, Edward A. (1-2)  
(D) Roessing, Lawrence W., Jr. (1-2)  
(D) Roos, David B. (1)  
(D) Sawyer, Kenneth C., Jr. (1-2)  
(A) Reimers, Wilbur L. (1-2)  
(D) Sides, Leroy J. (1-2)  
(D) Stanfield, Clyde E. (1-2)  
(D) Toll, Giles D. (1-2)  
(D) Blanchet, David (1-2)  
(D) Bosworth, Robert G., Jr. (1-2)  
(D) Butterfield, Donald G. (1-2)  
(D) Brock, L. Loring, Jr. (1-2)  
(D) Craigmile, Thomas J. (2)  
(A) Clifford, John H. (2)  
(D) Curry, Marcia F. (1-2)  
(D) DeLauro, John E. (1-2)  
(D) Elliott, Robert V. (1-2)  
(D) Engle, Stephen (1-2)  
(A) Gehret, Peter A. (1)  
(A) Gelfand, Daniel E. (1-2)  
(D) Gallagher, John Q. (1-2)

(D) Galloway, W. Ben (2)  
(A) Kail, Thomas J. (1-2)  
(D) Inkret, William, Jr. (1-2)  
(D) Leidholt, John D. (1-2)  
(D) Livingston, Wallace H. (1-2)  
(D) McElhinney, James P. (2)  
(D) Mitchell, Roger S. (1-2)  
(D) Mutz, Austin E. (1-2)  
(D) Nelson, J. Phillip (1-2)  
(D) Nieland, Leo J. (1-2)  
(D) Rainer, W. Gerald (2)  
(D) Sawyer, Robert B. (1-2)  
(D) Schemmel, Janet E. (1-2)  
(D) Smyth, Charley J. (2)

University of Colorado Medical  
Students - 3 Delegates

(A) Sceats, Donald L., Jr. (1-2)

#### **DISTRICT III - 17 DELEGATES**

Eastern Colorado - 1 Delegate

(D) Straub, John C., Jr. (1-2)

El Paso - 14 Delegates

(D) Baron, J. Gregory (2)  
(D) Cooper, Jack (1-2)  
(D) Hanson, Jerome R. (1-2)  
(D) Marta, John E. (1-2)  
(D) Martz, David C. (1-2)  
(D) von Minden, Milton (1-2)  
(D) Crawford, Lewis A. (1)  
(A) Baker, Robert W. (2)  
(D) Dawson, Dwight C. (1-2)  
(D) Lloyd, William D. (1-2)  
(D) Lovell, Kenneth R. (1-2)  
(D) Martin, Alfred J., Jr. (1-2)  
(D) Messner, Milo L. (1-2)  
(D) Pollard, Joseph S., Jr. (1-2)  
(A) Thompson, J. Robert, Jr. (1-2)

Intermountain - 1 Delegate

None Present

Lake - 1 Delegate

None Present

#### **DISTRICT IV - 18 DELEGATES**

Chaffee - 1 Delegate

None Present

Fremont - 2 Delegates

(D) Vincent, Jack F. (1-2)  
\*(A) Harris, Charles (1-2)

Huerfano - 1 Delegate

(D) Vialpando, Arthur B. (1-2)

Las Animas - 1 Delegate

None Present

Otero - 2 Delegates

(D) Knaus, Kendal C. (1-2)  
(D) Baumgartner, Robert B. (1-2)

Pueblo - 8 Delegates

(D) Boucher, Wesley W. (1-2)  
(D) Laman, Muryl L. (1-2)  
(D) Phelps, Harvey W. (1)  
(D) Dingle, Robert W. (1-2)  
(D) Dwyer, Rodney C. (1-2)  
(D) Lenz, Theodore R. (1-2)  
(D) Smith, Harold J. (1-2)

San Luis Valley - 2 Delegates

(D) Kenoyer, M. Ray (1-2)

Southeastern Colorado - 1 Delegate

(D) Krausnick, Keith F. (1-2)

#### **DISTRICT V - 15 DELEGATES**

Delta - 1 Delegate

None Present

La Plata - 2 Delegates

(D) Edgerton, J. Craig (2)  
(A) Grenoble, David C. (1-2)

Mesa - 5 Delegates

(D) Nelson, Kenneth E. (1-2)  
(D) Huskey, Harlan B. (1-2)  
(D) Painter, M. Ray, Jr. (1-2)

Montealores - 1 Delegate

None Present

Curecanti - 2 Delegates

(D) Tarr, John S., Jr. (1-2)  
(A) Canfield, Thomas M. (1)

Mount Sopris - 2 Delegates

(A) Kearse, William O. (1)  
\*(A) Jacobs, Mary Jo (1-2)

Northwestern Colorado - 2 Delegates

(D) France, David W., Jr. (1-2)

\*Substitute Alternate appointed to fill a vacant seat.

1 - Attended first meeting of the  
House of Delegates.

2 - Attended second meeting of the  
House of Delegates



## MRO Set for Heart Research

Among other things, the heart is the "vital center of one's being," and so the MRO called The Rocky Mountain Heart Research Center, newly established in Denver's St. Luke's Hospital, is a significant addition to the Colorado medical community.

The MRO is distinctive for being as a Medical Research Organization the first in the Rocky Mountain region, and one of the very first anywhere.

Under the direction of its president, Dr. Fred W. Schoonmaker, the Center concentrates on four specific areas:

- Study of methods and technics for evaluating the size and severity of heart attacks so that the most effective treatment procedures may be utilized.

- Research of criteria for determining when surgical intervention is required for well-being.

- Examination of how lifestyle modification, especially exercise, alters cardiovascular disease risk factors.

- Investigation of such totally unexplored areas as the effect of high altitudes on cardiovascular performance in the sick and in the well.

Already cardiovascular research in this country has added three years to the life span of a male, and four years to the life span of the American female.

The MRO stems from a recently written Internal Revenue Code regulation which requires that an MRO:

- Engage solely and directly in the continuous active conduct of medical research.

- Must do the research in conjunction with an already existing, staffed and equipped hospital.

- Allow for private funds which are tax deductible, to be donated to a not-for-profit 501 (c)3 organization.

It was the accomplishing of these ends with no duplication of costs for the building, apparatus, staff, and with a pre-existing patient census which appealed to the IRS. The MRO is funded privately, and a campaign of fund-raising from individuals, foundations, and corporations is now being carried on.

Founder-President Doctor Schoonmaker received his MD from the University of Colorado Medical Center, and completed his internship, residency and special training at Duke University Medical Center. He has lectured and written on cardiovascular problems extensively. He is a Fellow of the American College of Cardiology, the American College of Physicians, the American College of Chest Physicians, the American College of Angiology, the International College of Angiology, and is a charter and founding member of the Society of Cardiac Angiology.

### RESIDENTIAL SITES INVESTMENT OPPORTUNITIES STEAMBOAT SPRINGS WILLETT HEIGHTS SUBDIVISION

Incorporated in the city of Steamboat Springs. Above town, sunny, great views, paved roads and all utilities to lot lines, Single family lots and larger multi-family parcels available.

Peter Looram  
CDS - Steamboat, Ltd.  
(303) 879-5828

Obtain the property report required by federal law and read it before signing anything. No federal agency has judged the merits or value, if any, of this property.

# From patient record to claim

John P. Doe  
319 South First  
Atlanta, Georgia

4/20/79 Subjective: "Voice hoarse for 3 wks"  
Objective: hoarse, stridulous breathing. DTR: 2-  
Appraisal: Hypothyroidism (possible)  
Plan: Well asked for Hb ASAP to evaluate  
5/10 S: See complete history  
O: See phys exam summary  
A: Hypothyroidism, degree undetermined  
P: T3, T4, T7  
CBC to R/O anemia of hypothyroidism  
5/17 Brief pt ed visit.  
Hypothyroidism discussed with  
degree of hypofunction, women  
Serum cholesterols  
Plan: Will check lipids on  
Sched return appt 12  
and therapy.

## REQUEST FOR MEDICAL INFORMATION

### PART I—PATIENT TO FILL IN

Copy to  
YOUR OWN  
HEALTH  
INSURANCE  
CARD  
See example  
on back

3 Patient's complete mailing address (including Apt. #) 319 S. First Street At

4 Describe the illness or injury for which you received treatment (not complete Part II below)

5 If any of your medical expenses are paid by Health Insurance, please attach a copy of the insurance card to this form. Name and address of health insurance company Health Insurance Company

Note: If you Do Not want information about this Medicare claim sent to the Financing Administration or its intermediaries or carriers, you must attach a copy of this authorization to be used in place of the original, and to the party who accepts assignment below.

Signature of patient (See instructions on reverse where patient signs) SIGNATURE ON FILE IN YOUR OFFICE

SIGN HERE

### PART II—PHYSICIAN OR SUPPLIER TO FILL IN

7	A. Date of each service	B. Place of service (See Codes below)	C. Fully describe surgical or medical procedure and other services or supplies furnished (each date given in lab service indicate automated)	Procedure Code
	5/10/79	0	OFC INTER EST PT	90
	5/10/79	0	THYROID T3 T4 T7	84
	5/10/79	0	CBC	85
	5/17/79	0	OFC BRIEF EST PT	90
	5/17/79	0	CHOLESTEROL	82

8 Name and address of physician or supplier (Name, address, city, state, ZIP code)

Usher, DF  
6784 Peachtree St.  
Atlanta, GA 30301

9 Signature of physician or supplier (See instructions on reverse where physician or supplier signs)

X I do not accept assignment of benefits

*[Signature]*



# Form in one painless step.

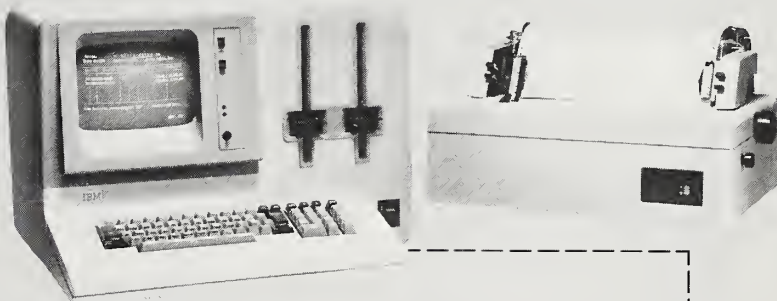
If medical insurance forms are a major bottleneck in your practice, IBM may have precisely the cure you're looking for. It's the new IBM 5120 Doctors Office Management System, developed for physicians confronted with increasing office costs and workloads. One of a family of IBM systems for the medical community, it's ideal for offices with one to three doctors. The system can handle up to 120 patient visits a day, and it runs on our smallest computing system, the IBM 5120. The total investment is less than \$19,000.

We call it painless because standard insurance forms are a by-product of regular patient billing information. Charges are entered into the 5120 from patients' records and the claims forms are prepared by the system's printer. But the 5120 can do more than help with insurance forms. You can have patients' bills ready before they leave the office. Answer questions on their accounts over the phone. Develop reports for practice analysis. And track patients for follow-up visits and periodic examinations.

Faster completion of claims forms often means faster payment and improved cash flow. And by getting a record of past-due accounts whenever you ask for it, chances are you'll speed the collection of accounts receivable.

The 5120 can handle many routine, repetitive clerical tasks. And someone in your office can usually learn to operate it in just a few days.

The IBM 5120 can help halt spiraling office costs. And give you more time for patient care and keeping up with developments in your field. Which is the best medicine of all. For further information on the IBM 5120, send in the coupon below. Or call your local IBM General Systems Division office.



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Yes, I would like more information on the IBM 5120 Doctors Office Management System.

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# PRACTICE MANAGEMENT SEMINARS

## Sponsored by the COLORADO MEDICAL SOCIETY

### I. OFFICE MANAGEMENT IMPROVEMENT

Presented by:

Medical Administration Resource Center (M.A.R.C.)  
Keith D. Ketelson, President  
C. Kay Freeman, Executive Vice President  
20 East Cimarron  
Colorado Springs, Colorado

Place:

Two Rivers Plaza  
2nd and Main  
Grand Junction, Colorado

Date:

May 8 and 9, 1980

Time:

May 8: 8:00 a.m. to 5:00 p.m.  
Physicians  
May 9: 8:00 a.m. to 5:00 p.m.  
Office Staff

Tuition:

\$75 per physician and one accompanying  
office staff member  
\$40 per resident  
(Make checks payable to CMS,  
1601 East 19th Avenue, Denver 80218)

#### PROGRAM:

##### PERSONNEL ADMINISTRATION

- Hiring Practices
- Motivation and salary administration
- Termination procedures

##### TIME MANAGEMENT/SCHEDULING

- Patient appointments
- Screening and registration
- Physician productivity
- Referral policies

##### BILLING/COLLECTIONS - Goals and Objectives

- Communications
- Recording charges
- Credit policies
- Aging accounts
- Insurance processing
- Effect of collection laws

### II. MANAGEMENT SKILLS FOR PHYSICIANS

Co-Sponsors:

Colorado Medical Society and American  
Medical Women's Association

Presented by:

Carroll Halterman, Ph.D.  
David E. Fletcher, Ph.D.  
Townsend Hopper, Ph.D.  
Mary Butler, J.D.  
Lucy Zanon, C.P.A.

Place:

Denison Auditorium  
University of Colorado Medical Center  
4200 East Ninth Avenue  
Denver, Colorado

Date:

May 10, 1980

Time:

8:00 a.m. to 5:00 p.m.

Tuition:

\$75 per physician  
\$40 per resident  
\$15.00 Medical students

Make checks payable to American  
Medical Women's Association  
Att: Mary Catherine Curry, M.D.  
701 East Colfax Avenue  
Denver, CO 80202

#### PROGRAM:

##### ESTABLISHING A PRACTICE

- Location
- Forms of Practice
- Legal Aspects

##### INSURANCE

- Billing
- Collections
- Staffing

##### MONEY MANAGEMENT/WORKING WITH PEOPLE

- Patients
- Office Personnel



## Adult Foster Care Provided

The Colorado State Department of Health has announced the development of a new program for Adult Foster Care. The program is offered as a human alternative to institutionalization and isolation for the many adults who are ambulatory, free of communicable disease, capable and willing to care for personal hygiene with minimal assistance, generally oriented as to time, person and place, and are able to adjust to social environments. The person may be controlled by medication if subject to Grand Mal seizures, and able, with supervision, to take his own medication.

This program provides a supportive homelife for adults who might be forced to live in isolation or in a nursing home. It provides a general, non-medical supervision for adults who cannot safely live alone, yet want to be as self-sufficient as possible.

The program now is in operation in the following Colorado counties: Bent, Boulder, Denver, El Paso, Jefferson, Kiowa, Kit Carson, La Plata, Larimer, Morgan, Prowers, Pueblo and Weld.

Those persons interested in opening their homes to such adults or who know of an individual who would benefit from such care should call the Adult Foster Care Caseworker at the County Department of Social Services in the above counties.

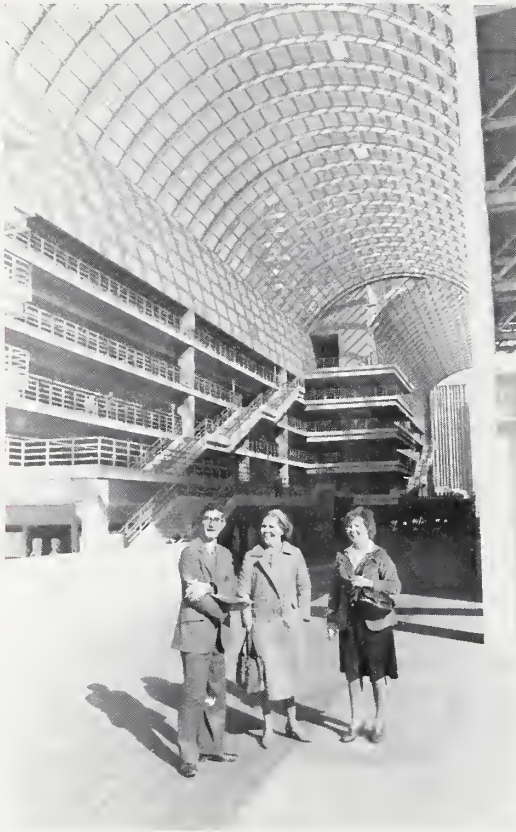
Incidental to the Adult Foster Care program, but still important to geriatric research in Colorado is

the new awareness of the needs of elderly persons living alone. An example of this comes from gerontologists studying the ability of persons to live alone in the high-rise, "senior homes" that burgeoned in the '70s. It was found that elderly persons who were left to their own devices and who chose to live in these buffet or larger apartments were soon suffering, in many cases, from malnutrition. Even though the new apartments were fully equipped for house-keeping, older people lost the desire to prepare proper meals for themselves. Some were found to be eaking out a nutritional existence on snack portions of food which did not satisfy the need for daily nutritional intake. Persons, organizations or developers of senior homes are now warned that their planning must involve the necessity of each such home providing a central dining facility in which all residents of the home must take at least one meal per day. This, then, would necessitate the residents leaving their apartments and being made to mingle with other residents, helping to ward off the physical and mental atrophy which so often accompanies aging. It would provide that vital motivation to the person to share in a meal which can be dietetically planned and emotionally or socially stimulating, both important to the elder person's continued independence and happiness.

**LIVING WELL IS  
THE BEST REVENGE...**  
**with Mark Cross...its a way of life**



**BROADMOOR WEST**  
Colorado Springs  
632-0522



It was a different lobby for CMS Lobbyist Carol Tempest and Staff Assistant Lorraine Koehn of the Government Affairs Division, when they joined a recent legislative tour of the Helen Bonfils Theatre Complex at the Denver Center for Performing Arts. The theatres opened New Year's Eve with Brecht's "The Caucasian Chalk Circle," directed by Edward Payson Call, Artistic Director of the resident Denver Center Theatre Company. The opening season concluded March 30.

## At The DCPA

Carol Tempest (center) and Staff Assistant Lorraine Koehn paused to talk with Vince Ryan of the Denver Center for Performing Arts staff as they entered through the huge and beautiful galleria off of 14th Street at Curtis. The Center parking garage is to the left, and the Auditorium Theatre and Arena are to their right.

Vince, Carol and Lorraine met the tour group in the lobby of the Denver Center Theatre, which is actually three theatres in one building. Hanging over the lobby is the sign indicating "THE SPACE," smaller of two stage theatres located in the area beyond. To the left, and out of sight is the entrance to "THE STAGE," the second legitimate stage theatre. A third theatre, this one to be dedicated and named on April 24th after Frank Ricketson, Jr., prominent Denver citizen, is scheduled to show over 500 American and foreign films (old and new) each year.

The DCPA contains three theatres, two live stage theatres, and the third a cinema, to be dedicated and named for Frank Ricketson, Jr., (recently honored as Citizen of the West), a prominent Denver citizen, on April 24th. That date will be the opening of a week-long Fairbanks Film Festival, honoring Douglas Fairbanks and Douglas Fairbanks, Jr. Fairbanks, Senior, was a native of Denver, and Fairbanks, Junior, has been associated with Denver theatre and the Denver live stage for many years, and has been involved in the planning and development of the Denver Center since its inception. Douglas Fairbanks, Jr., will be on hand to honor Frank Ricketson, Jr., and to introduce one of his father's films, which will be a part of the dedication celebration.







A spectator's view of part of "THE STAGE" theatre . . . with seating around the stage in a 280 degree circle, so that no spectator is more than 60 feet from center stage. Stage design, lighting, on- and off-stage movement is excellent and carried out in a most effective manner. The set is from the first production, "Caucasian Chalk Circle."

When you visit Denver you will enjoy a wide variety of entertainment and culture by partaking of the productions at the Denver Center for Performing Arts, whether it be concerts by the Denver Symphony Orchestra in Boettcher Concert Hall, either of the stage productions by resident Denver Center Theatre Company, or classic films in the Frank Ricketson Cinema, or even Broadway or national production companies appearing in the Denver Auditorium Theatre. There are also many athletic events held in the Denver Auditorium Arena . . . all facilities just a few steps away from street or garage parking.

Vince, Carol and Lorraine as they leave the Denver Center Theatre following a complete tour of the combined theatres . . . all in one building . . . standing near the geographical center of the multi-media cultural and entertainment plaza.



# Radiation standards and the control of radiation exposure

Edward A. Putzier, BA, Health Sciences and Industrial Safety Manager

*The fact that persons in Colorado are subjected to natural radiation doses of approximately 180 mrem/yr., about twice that at sea level, is something about which very little can be done. Over the past several decades, however, much has been done in improving control of radiation exposure to radiation workers and to the general public living near nuclear facilities. This article deals with the latter and relies heavily on the experience of the writer at the Rocky Flats Plant operated by Rockwell International.*

## Introduction

Controlling radiation exposure, whether it be to radiation workers or to medical patients, requires knowledge of the nature of radiation and of the associated parameters affecting transfer of radiation energy to living tissue. Radioactive material taken into the body results in "internal exposure." Once in the bloodstream, the material may "seek" particular organs. For example, plutonium tends to go to bone and liver. Energy imparted to the organ depends on quantity, the radioactive half-life and the biological half-life, for elimination.

"External radiation" relates to radiation entering the body from the outside, such as diagnostic x-rays. The unit of radiation for both external and internal radiation is the Rad — equivalent to an energy transfer of 100 ergs/gram in body tissue. Different types of radiation for the same energy deposited show different degrees of effectiveness for biological changes. The dose-equivalent unit accounting for the difference is the Rem. Doses expressed in Rems are therefore additive regardless of radiation type. Radiation standards are therefore stated in terms of the Rem unit.

## History of Standards

Although harmful effects from high-level radiation had been observed near the turn of the century, it was not until 1928, at the second International Congress of Radiology in Stockholm, Sweden, that an international effort was

begun to establish uniform protection recommendations for x-rays.<sup>1</sup> This meeting initiated considerable activity, both nationally and internationally, in the radiation protection field. Handbooks published by the National Bureau of Standards were for many years used as guides for both occupational and non-occupational exposure control. Internal standards for "bone seekers" such as plutonium were established based on observed radium exposure effects (approximately 60 years ago) to radium dial painters. The standard is given as a "maximum permissible body burden" expressed in activity units, usually nanocuries (nCi).<sup>\*</sup> The resultant internal standard for plutonium is 40 nCi and has remained at this value for approximately the past 30 years. The external standard for whole body exposure, however, has decreased from 0.1 Rem/day in 1947 to the current 5 Rem/year. Perhaps the best explanation for this decrease came from a statement in June 1977 by Dr. Lauriston S. Taylor, who has been active in standards review since the 1928 Stockholm meeting. His report before the Committee on Commerce, Science and Transportation, U.S. Senate, is quoted as follows:<sup>2</sup>

"... during all of the periods since 1934, the changes in permissible dose standards which have been introduced were not because of new data indicating radiation to be more hazardous than previously thought. The changes were introduced primarily because of the practicability of accomplishing lower radiation exposure levels in keeping with the practical needs of the scientific, medical and engineering community."

## Standards and Their Application

The Environmental Protection Agency has for the past decade been responsible for setting radiation standards. Standards are currently under review and public hearings are expected sometime this year. The current whole body exposure standard is 5 Rem/year, the internal "systemic" standard for plutonium is 40 nCi, and the standard for lung burden is 16 nCi.

Rocky Flats policy is to restrict an employee from further plutonium work if an exposure re-

Mr. Putzier is Health Sciences Director for Rockwell International at the Rocky Flats Plant. He received his BA from Mankato State College, Minnesota in 1950, and in 1950-52 took an AEC sponsored Radiological Physics Graduate Fellowship program at the University of Rochester, New York. In 1961 he was Certified by the American Board of Health Physics.

\*A nanocurie is 10<sup>-9</sup> curie and is equivalent to an atomic disintegration rate of 37/second.



sults in 50 per cent or more of a maximum permissible systemic burden or 100 per cent or more of a maximum permissible lung burden. A lung burden tends to decrease within a reasonable time due to normal elimination process so that an employee can, in time, return to his job. Systemic burdens, however, decrease very slowly. While Rocky Flats has not experienced exposures in excess of external exposure standards in effect over the years, some restrictions would be imposed should the standard be exceeded.

For the past ten years or more industry has emphasized the concept of As Low as Reasonably Achievable (ALARA) to control exposures. This has resulted in doses much lower than the standards. However, the flexibility for job assignment, which is allowed under current standards, has played an important role in effectively reducing exposures to the total worker population. Radiation dose standards for the general public have also become more restrictive over the years, decreasing from about one-tenth of the occupational standards to one-thirtieth to even more restrictive levels.

#### **Exposure Control**

Two principles are fundamental to external exposure control. Radiation dose is directly proportional to time, but, as is the case for ordinary light, decreases inversely with the square of the distance; e.g., doubling the distance reduces the radiation intensity by a factor of 4. These two principles are not always adequate in themselves and radiation shielding and/or remote handling technics are sometimes necessary.

Internal exposure and control of environmental releases in the industrial setting relies on containment, properly engineered ventilation and filtration, air sampling monitors to warn workers of accidental releases of radioactive particulates in the workplace, and availability of properly fitted respiratory equipment to be used should a release occur. Daily radiation surveys, and health and safety reviews of new or planned facilities and operations are also an essential ingredient to assure maximum control for both workers and the environment.

#### **Exposure Assessment**

Radioactive material can enter the body in four ways: Inhalation, an open wound, absorption through skin, and ingestion. The latter two are, in general, inconsequential and lead to very little uptake. A fraction of any material inhaled will remain in the lung and some will be absorbed into the bloodstream. Similarly, part of the material in an open wound may enter the bloodstream. Removal of material from a wound is usually successful through normal cleansing or simple medical procedures.

"Systemic" burden is estimated from measurement of plutonium in urine. The calculation to convert from radioactivity in urine to "systemic" burden, is based on work originally done by Dr. Wright Langham.<sup>3</sup> The calculations are complex and require computer assistance. For purposes of lung burden determination, highly sensitive radiation detectors, placed over the chest, can be used to make an estimate in about 30 minutes. External radiation dose for many years was determined from photo-sensitive film similar to that used for dental x-rays. Use of film had several technical problems requiring extreme care in analysis procedures. In the past 10 years most of industry has turned to the much more easily handled thermoluminescent dosimeter. These dosimeters utilize materials such as lithium fluoride or calcium fluoride which, when subjected to radiation, store or accumulate a response which is measurable.

#### **Summary**

With improved technology and the practicability of achieving lower radiation exposure levels, standards have been reduced over the years. Improved technologies in radiation dose assessment have also contributed. With the dedication to and the emphasis on the As Low as Reasonably Achievable concept, industry has proved that personnel exposures can be kept well below the standards. Further reduction of standards seems at this time unnecessary and could have an adverse effect on what has been achieved if flexibility for utilization of individual skills built into the present standards is removed.●

#### **REFERENCES**

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- <sup>2</sup> "Study of Anticipated Impact on DOE Programs from Proposed Reductions to the External Occupational Radiation Exposure Limit," U.S. Department of Energy publication DOE/EV-0045, 1979.
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## COLORADO MEDICAL SOCIETY COMPLETES ONE YEAR ON "DENVER NOW."

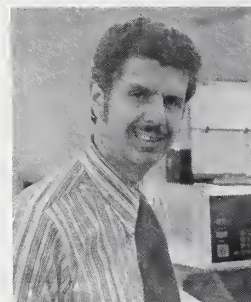
KWGN-TV, Channel 2, in Denver has provided the Colorado Medical Society with a weekly television outlet to reach many people in Colorado, Wyoming and Nebraska. Each Wednesday at 9:30 am, KWGN's Beverly Martinez hosts the "DENVER NOW" program, during which the Colorado Medical Society has been featured. Beverly invites CMS to pick the subject and the guest to appear on the program, live, and she does the rest: an excellent job of interviewing concerning a wide variety of medical subjects. Greg Guinan, Vice President and Director of Public Affairs at WGN-Colorado says the society's segment of the half-hour program gets the best public response and inquiry of any of the station's public affairs programs, and KWGN provides many such programs. In addition to the "DENVER NOW" program, which airs each morning for a half hour, KWGN is now broadcasting an hour-long, monthly "TOWN MEETING," including a live audience participating with a panel of experts on the subject of the evening. In the month of May the program will be devoted to medical and health care subjects. The Society has been able, through KWGN and "DENVER NOW" to discuss many areas of health care and medical treatment which are not often approached in this type of one-on-one interview. The Colorado Medical Society salutes KWGN for its public involvement in presenting these worth-while programs.



Ray G. Witham, M.D., President, Colorado Medical Society, the guest on "DENVER NOW" with hostess Beverly Martinez, KWGN-TV, Channel 2, Denver. Doctor Witham discussed rural health in Colorado with Beverly on this recent program, which reaches all corners of Colorado, much of Wyoming and western Nebraska. The CMS segment of the program is broadcast, live, each Wednesday morning at 9:30.

## staff profile

Midst the hum of copy machines, whirring of presses and the smell of printer's ink, stands Dick King, a valuable asset to the Office Services Department where he began work almost one year ago. Dick is one of two key operators of Xerox printing and assists in many of the tasks in a busy mail room and print shop.



His work includes a variety of incoming mail processing, outgoing mail labeling and addressing, printing of many of the Colorado Medical Society's and Colorado Foundation for Medical Care's materials.

Born in Pittsburgh, Pa., Dick grew up in Denver where he attended Byers Junior High School and South High School. Before coming to work at Colorado Medical Society, Dick worked in the Denver area as a bank teller, sales clerk, even did a stint as assistant manager of a Cripple Creek gift shop.

Among his many talents, Dick is also an accomplished artist. He has served as Vice President and Program Chairman for the Aurora Art Club on two occasions. Many of Dick King's oil and oil-pastel paintings have been displayed in banks and hospitals throughout the region. Among his paintings are portraits of friends, relatives and even members of the Denver Bronco football team. In the future, Dick hopes to contract for and market his portraits of the Broncos for Denver fans of all ages.

Dick has two sons (Bradley, 12, and Grant, 11) who have been very active in sports, especially wrestling. Both boys finished in the top two places in their weight division in a multi-city tournament this March.

Dick King truly enjoys his work with the CMS/CFMC Office Services Department. He tells *Colorado Medicine* "I enjoy the variety of duties in my job and my work with the many excellent and friendly folks here."

Dick King, artist, printer, father, the man behind the machines and one of the staff of Offices Services at CMS/CFMC.



# WHY SHOULD YOU WANT



It's time to crow a little . . . about our tremendous success with the Colorado Medical Society and CMS Auxiliary project, "Why Should You Want Health Power?" Over a hundred thousand of these little pamphlets have been or are being distributed to physician's offices, clinics, business offices, industry, government, hospitals, out-patient and emergency facilities. People are still calling in, asking if they can have some for their own clubs, organizations, and families. GREAT! But there is one hitch: we have had to limit the circulation to 300 copies per CMS member, and any additional will cost 1c apiece.

How are seven HEALTH POWER HABITS your physician wishes you had to you can have:



THERE'S MORE! Health Power won't stop . . . we want this banner to become an integral part of every Coloradan's life . . . before anyone HAS to call a doctor. Keep the pamphlets going out . . . keep up the good work. Colorado Department of Education and the Colorado Public Health Association, in cooperation with the Colorado Medical Society, is conducting a state-wide school poster contest. We're going to have every public or private school student from kindergarten through high school talking about and demonstrating ways the individual can improve his or her health. It's a great program, and you have been extremely helpful. Coloradans appreciate your interest and concern, so let us hear from you on re-orders, on other ideas where we can be of help.

## CARL AKERS HONORARY CHAIRMAN FOR 1980 MERCY MEDICAL CENTER FUND-RAISER

Colorado author and television news commentator Carl Akers of KBTU-Channel 9, Denver, has been named the Honorary Chairman of the 1980 GALA, a fund-raising event for Mercy Medical Center health care programs. The theme of this year's event is "For the Love of Mercy." Proceeds from the 1980 GALA will help support new and ongoing programs such as Mercy's Adolescent Alcoholic Care Unit, Intensive and Coronary Care Units, Cochlear Ear Implant for the deaf, and Intraocular Lens Implant for cataract patients.



Carl Akers began his communications career with KLZ Radio in Denver following graduation from the University of Missouri's School of Journalism in 1948. For 12 years Carl was the familiar fixture on Channel 7's news before moving to Channel 9 in 1968. In 1977, only after 22,000 plus newscasts, Carl was named Commentator and Vice President of KBTU. Carl has joyously researched and laboriously published two books: *Carl Akers' Colorado*, published in 1975, and *Carl Akers' Comments*, published in 1979.

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**ROCK SPRINGS, WYOMING - EMERGENCY MEDICINE PRACTICE AVAILABLE IN STABLE FIVE PHYSICIAN GROUP.** Excellent fee for service contract, seeing variety of trauma and medical patients. New hospital with specialty back up. Ideal location with proximity to Jackson, Steamboat Springs, and Salt Lake City. Send CV to Box 779-10-TFB, c/o Rocky Mountain Medical Journal, 1601 East 19th Avenue, Denver, Colorado 80218. 779-10-TFB

**PRACTICE OPPORTUNITIES IN THE NORTHWEST.** Our firm manages a number of hospitals in communities in Northwest. For information regarding practice opportunities send your CV to Dale Hanson, A.E. Brim and Associates, Ltd., 177 N.E. 102nd Avenue, Portland, Oregon 97220, or call: (503) 256-2070. 979-1-6B

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**FOR SALE: USED MEDICAL OFFICE ITEMS.** 3M Secretary Copying Machine. Time Master Dictating Machine (Dictaphone) 3M Portable Copier. Birtcher Electrograph Machine, stand. Record-a-Call telephone answering device. Radio Shack Duophone Answering Machine. Metal typewriter table. Office incubator. Castle table sterilizer. Tyco wall sphygmometer. Burdick Diathermy machine. Adjustable office examining stool. Office balance scales. Eder flexible gastroscope. Wood examining table and cabinet. Office furniture. Frigidaire refrigerator, 6 cu. ft. Call: (303) 322-6104 if interested, between 2 p.m. and 5 p.m. Tuesdays and Thursdays, and Mondays from 10 a.m. to 12 noon. 480-2-1B

**EXCELLENT OPPORTUNITY FOR FAMILY PRACTITIONER** to work full time in a licensed Community Clinic and Emergency Room. Near year-round recreational activities, 30 miles from Denver. Write: Bruce Garlinghouse, Evergreen Medical Clinic, P.O. Box 5079, Evergreen, Colorado 80439. Include curriculum vitae please. 480-3-1B

**UNIVERSITY OF WYOMING — PHYSICIAN, STUDENT HEALTH SERVICE.** The position of Staff Physician will be open by July 1, 1980. Applicants must be Board Certified in either Family Practice or Internal Medicine and primary care experience in practice is preferable. Applicants should have strong interest in developing innovative programs for the student body as well as medical students and family practice residents. Position requires a Wyoming license and carries a clinical faculty appointment in the College of Human Medicine. At present there are three staff physicians and the Director of the Student Health Service. There are also two nurse practitioners and a supporting staff of 25 people. The Health Service has its own laboratory, x-ray, pharmacy, physiotherapy unit, infirmary (6 beds), and mental health consultants. The Student Health Service is administered by the College of Human Medicine and serves 9,000 students on the campus at Laramie, Wyoming. The College and the Student Health Service are working closely to develop a teaching program through the Student Health Service. Twelve month position, salary competitive. Submit resume by June 1, 1980 to Dale Brentlinger, M.D., Director, Student Health Service, Box 3068 University Station, Laramie, WY 82071. **THE UNIVERSITY OF WYOMING IS AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER.** 480-4-2B

## want ads

**PSYCHIATRIST** — Board eligible, with training or experience and interest in community work. Full-time position serving three counties in a five-county program with 22 other professionals. Opportunities for outdoor recreation and rural living as well as excellent fringe benefits, including ten days and \$800 annually for professional development. Special opportunity for a psychiatrist with interest in the unique social environment of an energy related "boom" community. Interest and experience with children and adolescents desirable. Salary range \$50,000-\$60,000. Mail resume to: Janet W. Livingston, Administrative Assistant, Northern Wyoming Mental Health Center, 36 North Brooks, Sheridan, WY 82801. 480-5-2B

**WANTED: RADIOLOGIST** for solo practice in Steamboat Springs, Routt Memorial Hospital. Available June 1, 1980. Excellent resort and facilities. Ultrasound now and Nuclear Sound in the future. Send resume to: Mr. Thomas Flickinger, Administrator, Routt Memorial Hospital, P.O. Box 970, Steamboat Springs, Colorado 80477. 480-8-1B

### PROPERTIES — FOR LEASE

**FOR LEASE:** Medical office space in Lakewood, Colorado building. Suite for one doctor and some equipment available. Immediate referrals. Call: (303) 238-4811. 579-12-TFB

**SOUTHEAST DENVER.** Medical-Dental Space available. Up to 6400 sq. ft. Call: (303) 777-2639. 480-1-1B

**SUBLFT MEDICAL OFFICE.** Front Range Medical Arts Building next to St. Anthony Hospital North. Half-day a week or more as needed, with X-ray facilities. Phone: (303) 421-7716. 480-9-1B

**MEDICAL OFFICE SPACE AVAILABLE TO SHARE ½ DAYS.** 1100 sq. ft. in the beautiful new Denver Technological Center at East Belleview and I-25. Completely furnished and equipped. Terms negotiable. Call: (303) 770-3172. 480-7-1B

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**FOR SALE: OFFICE-CLINIC OPPORTUNITY.** 26th and Federal Boulevard, Denver. Remodeled ranch with basement. Zoned B-2. 870 sq. ft. Two car garage. Large front yard could be patient parking area. Contact: Larry Addington, Coldwell Banker Residential Brokerage, 4890 Kipling Street, Wheat Ridge, Colorado 80003, or Call: Office (303) 425-6526, or Home: 420-1688. 480-6-1B

### SERVICES

**MOVING TO COLORADO?** We have a super transferee information kit - Free, upon request. Write: Penny Decker, Relocation Director, Hutson Real Estate, 2731 South Colorado Boulevard, Denver, Colorado 80222, or Call: (303) 758-8821. 1179-9-6B

**MEDICAL TYPING DESIRED.** Expert typist with background in hospital medical records transcription and doctor's office medical typing desires typing to do at home. Have own IBM Selectric II. Prefer work from South Suburban area of Denver. Can pick up and deliver work. Call: (303) 773-0775. 280-3-4B



## RURAL HEALTH AND THE RURAL PHYSICIAN AGAIN POINTED OUT AS LEADING STATE PROBLEM

Rural health services is one of the five most important problems facing the State of Colorado, according to Senator Martin Hatcher (D), who represents eleven western slope counties.

Senator Hatcher, speaking recently in Denver, pointed out that in his list of state priorities there were five crucial areas today:

- 1) Agriculture.....farm economics are "simply terrible" at this time. The major industry of Colorado is facing a 23% reduction in income in 1980. Lack of a clear set of government policies, especially federal policies, toward agriculture make the industry even more risky. The farm community has lost touch with the rest of society, turning them anti-social and anti-government.
  - 2) Development of Natural Resources.....there's a new movement: the "politics of resource management;" Government intervention and management of resources, concerning economic resources and "in the rural areas we do have all of the natural resources. You have most of the capital, but we have the resources." Senator Hatcher pointed to Colorado as "the world in a microcosm, I guess you could say. We do have all of the attention focused on that energy, most of it, oil shale, coal, uranium and all, in those western slope areas."
  - 3) Economy for small business....."Those small businessmen have the same number of forms to fill out a giant corporation. One of the reasons why he is a small business is because he was trying to get away from all that red tape." Today's economy is fast growing away from any "small business."
  - 4) Health and education in rural areas....."One reason that people have, during the past three decades, deserted and left small towns was so they could get better health care and educational advantages." Senator Hatcher pointed out "The health facilities are not as good in the rural areas. There are half as many doctors, per-capita, as there are in the city. Chronic disease and infant mortality are higher in the country. Income is about half what it is in the city. Part of the problem: whenever we have medically indigent, or even the poor, they generally gravitate to the city where help is available, and then they become the city's problem."
  - 5) Rural residents of Colorado have grown increasingly withdrawn from society, distrusting the city and government....."There is this enormous distrust of the city and government." Senator Hatcher said that his own formula for this phenomenon is that the further you are from the city and the seat of government, the more you distrust both. "The real issue, I think, is geopolitical. Simply, no state in the nation is as divided geographically as we are. Each one of those mountain valleys has a different life style that they would like to keep.....in many cases different nationalities...different people."
- Senator Martin Hatcher, who represents eleven western-slope counties in his district, points out that people outside of Colorado, particularly in Washington, D.C., and along the eastern seaboard, just can't comprehend. Hatcher pointed out "I have an area larger, and that's just for one senatorial district, an area larger than Rhode Island, Connecticut, New Hampshire, Hawaii and the District of Columbia, all put together. We don't have a single U.S. Senator, a single U. S. Representative. We don't have any state-wide officers that are from that particular area."

The Senator echoed the sentiments of Governor Richard Lamm, in his address to the Colorado Medical Society House of Delegates in February, in that health and well-being of the people of Colorado is one of the major concerns of state government today.

## NEW AWARENESS, GREATER DIVERSITY IN SERVICES TO THE MEDICAL COMMUNITY

Since commencing the reorganization, which is still under way, the Colorado Medical Society has introduced new corporate management and innovative movements of the Society. As a whole there is a new air of realization about what Colorado Medical Society is doing on behalf of its membership.

In a recent issue of COLORADO MEDICINE, reference was made to the present services provided by the Society, and the question was asked of the reader "What of these other, potential services do you feel would be helpful or important to your own practice?" Reviewing the results thus far garnered, here's what the physician is saying:

Listed in the order of their importance to the respondent,

### SERVICES NOW PROVIDED:

- Disability Insurance
- Continuing Medical Education courses
- Practice Management courses
- Print Shop Services
- Term Life Insurance
- Physicians' Directory
- Teletran
- Placement services
- Intrav
- Professional Liability Insurance
- Judicial Mechanism
- Addressing/Mailing services
- Grievance Mechanism
- Legislative Lobbying
- Legislative (telephone) "Hot Line"
- Colorado Medicine magazine
- Accreditation of Health Facilities
- Specialty Society Office
- COCHEMS Trust Fund

### SERVICES BEING CONSIDERED:

- Car purchase discounts
- Major Medical Health Insurance
- Car leasing and rental
- Bookkeeping and Accounting services
- Collection services
- Temporary Help service
- Office Overhead Insurance
- Telephone Answering Service
- Paging Service
- Student Loans

What does all this mean? It means that the CMS staff, through the Board of Trustees, is attempting to provide a broad range of services to ALL physician members. In today's economic and political arena, your Colorado Medical Society is still the loudest, clearest single voice being heard on all fronts, in behalf of Colorado physicians.

The Department of Communications continues to work to make this voice heard at all levels, in all public media and forums. CMS needs your input, your voice, your views, your requests for service, your needs to be known to other physicians and the public at large. Let us hear from you.



## COLORADO MEDICAL SOCIETY MEDICAL CARE IN CORRECTIONAL INSTITUTIONS COMMITTEE

The Committee on Medical Care in Correctional Institutions met on March 29, 1980, to discuss recent developments in the Ramos case concerning inmate care at Colorado State Penitentiary.

During the meeting Mr. James Hartley, an attorney representing the plaintiff inmates in the Ramos case discussed with the committee recent requests by Judge John Kane, U.S. District Court, that representatives from the Colorado Medical Society be asked to testify before him during a hearing scheduled for April 14, 1980. This hearing will concern the most recent plan submitted by the Colorado Department of Corrections in proposed compliance with Judge Kane's previous order to correct deficiencies in medical care at the penitentiary.

John Buglewicz, M.D., Chairman of the Medical Care/Corrections Committee, has agreed that the Society will provide such input, as appropriate, and will continue to work with the Court and the Department of Corrections to develop improvements in the delivery of medical care in Colorado institutions.

Also attending the Committee meeting was Bob Moore, Director of Medical Services for the penitentiary. Mr. Moore has been an active participant in researching and reporting the needs of the prison inmate population.

## PHYSICIAN'S DIRECTORY DUE OUT SOON...BUT WE MUST HAVE YOUR RESPONSE CARDS

COLORADO MEDICINE published, in the March, 1980, issue a response card for member physicians to up-date their professional and personal information to be listed in the 1980 Physician's Directory.

The card asked that the information be returned by April 15, 1980.

We are URGING you to complete the card and return it as quickly as possible. This mountain of information must be inserted into the computer so that it can be properly and correctly printed in the 1980 Directory.

For those of you who anticipate a change in practice during June-July, please give the address and other pertinent information of your practice location.....WHICH WILL BE CORRECT AFTER JUNE 1, 1980. This will enable the editors of the Directory to reflect your correct address for the balance of the year that the Directory will be in use.

PLEASE.....go back right now to the MARCH, 1980, EDITION OF COLORADO MEDICINE.....find the inquiry card and complete all the questionnaire. We must have your help in publishing the Directory in a timely and correct fashion. The proposed date for publication and distribution of the Directory is June 1 - 15, 1980.

## STATE NURSING DISASTER COORDINATION COMMITTEE TO HOLD WORKSHOP

The Colorado Nursing Disaster Coordinating Committee will hold a one-day workshop on Thursday, May 8, 1980, in order to exchange and update information concerning potential state disasters, natural or otherwise.

The workshop will be held at the Elk's Club, 1455 Newland Street, Lakewood, Colorado (Use North entrance only).

Registration for the workshop is now open, but there will also be a registration desk, opening at 8:00 am, the day of the workshop.

If you wish to attend, please call one of the following:

Lea Pierce	575-2616
Eleanor Bent	399-0550, Ext. 218
Katy Delgado	238-6301, Ext. 202 or 235

## COLORADO SOCIETY OF OSTEOPATHIC MEDICINE TO CELEBRATE "OSTEOPATHIC WEEK"

The Colorado Society of Osteopathic Medicine, its Divisional Societies and Auxiliaries in Colorado will observe the first annual "OSTEOPATHIC MEDICINE WEEK IN COLORADO."

Colorado Governor Richard D. Lamm indicates he will proclaim the week of June 1 - 7, 1980, as "Osteopathic Medicine Week," with an appropriate signing ceremony in the office of the Governor early in May.

Society members are presently cooperating with editors of the Denver Post in assembling a special supplement to the Empire Magazine commemorating this event.

CMS is pleased to recognize the Society of Osteopathic Medicine for its work in the broad field of medicine, including a large number of Doctors of Osteopathy who are members of the Colorado Medical Society.

There will be a variety of events which will mark this special, week-long observance, and we'll be communicating more of these details during May. If you would like more information in the interim, contact the Colorado Society of Osteopathic Medicine at 4701 E. 9th Avenue, Denver, 80220, telephone 322-1752.

## ANOTHER REMINDER ABOUT "YOUR" RADIO PROGRAMS.. AND NEEDED RESPONSES

Colorado Medical Society's efforts to bring the physician closer to those persons in all parts of our state is having excellent response thus far; HOWEVER, if you have not completed the small questionnaire which appeared in the March COLORADO MEDICINE, please go back and find it on Page 99, read it over and fill in the appropriate blanks, send it back and be sure you'll be helping a large segment of the public to better understand your practice, your specialty and your profession. We are promoting the weekly radio program series in an effort to better tell the story of the physician and his local component society. Your participation will be greatly appreciated.





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Address all correspondence relating to subscriptions, advertising or address changes, manuscripts, organizations and other news items relating to editorial content to Editorial and Business Office.

Editorial and Business Office  
1601 E. 19th Ave.  
Denver, Colorado 80218  
Telephone (303) 861-1221

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*Colorado Medicine* (ISSN-0199-7343) is published monthly for \$12 per year by the Colorado Medical Society, 1601 East 19th Avenue, Denver, Colorado, 80218. Second-class postage paid at Denver, Colorado. POSTMASTER: Send address changes to *Colorado Medicine*, 1601 East 19th Avenue, Denver, Colorado 80218.

ight: 1980 by the Colorado Medical Society. All material subject to this  
ght appearing in *Colorado Medicine* may be photocopied for the noncom-  
al purpose of scientific and educational advancement.

Advertising: National representative: John H. Harling, Inc., 8 South Michigan Avenue, Chicago, Illinois 60603. Telephone: (312) 641-9755.

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# president's letter

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There is a necessary delay between the time I express my thoughts herein, and when the message finally gets into your "eager" hands to be read; please excuse me if what I say seems to be "old hat." Some of it will be just as pertinent five years from now, but I hope not.



First, I have had occasion to attend some interesting meetings and confrontations during the last week or two of April. Roy and Thelma Schwarz invited Maxine and me, along with a group of people including Senator Fred Anderson, to their home and a luncheon honoring three Arabian visitors. It is hard to believe that these people, who are so soft in external appearance and behavior, have such a heavy influence in our world and our future because of their nation's extreme wealth. One is immediately impressed with the high degree of their intelligence and purposeful intent, with their obvious seriousness in accomplishing an improved standard of living for their citizenry. This is why they were visiting in Colorado.

Dean Schwarz had been contacted by the Arabian people because they want to establish medical schools in their country, and need our knowledge and experience to accomplish this. An important facet of this is the proposed development of educational communication satellites to carry information between the United States and Saudi Arabia and other Mid-Eastern countries. This can have a great impact in our political relationship to that area, as well as the potential of developing new and innovative communication technics for all of us in North America and in Colorado. The Arabian guests indicated to me that they have the finances to launch this project and they were here as Roy Schwarz's guests to discuss this matter. Maybe a few heads of departments at the Health Sciences Center don't see eye to eye with our new Dean, but there are many others of us who do, for those reasons mentioned here, as well as many more.

Another matter of concern and, hopefully, interest to the membership of Colorado Medical Society is the media, particularly print, which seems to delight in printing matters concerning

our financial resources and income, plus taking a great delight in printing letters of conflict including patient versus doctor, and doctor versus doctor. I guess it is typical of what they view as public interest or they wouldn't print it. We know that it is a matter of public interest, but it totally escapes me as to why we continue to feed the press with any information or comment seems to be detrimental to our total, professional commitment.

Believe me: I am aware of the fact that you and I as physicians have spent between 25 and 30 years in educating ourselves in our profession and, for the most part, have paid every cent of the cost ourselves. Without much exception, why must we deign ourselves to debating these third-party differences in our areas of conflict with the press? I think we should not! There are important areas of concern to me and to the leadership of your society. Let us know your concerns and we will deal with the problem to the best of our ability, and in the proper arenas.

Finally, our best areas of concern are the matters of preventive medicine, relationships with youth and their leadership roles of tomorrow, helping the poor and disadvantaged and mandating such things as public health and protection, e.g., the reinstatement of the motorcycle helmet law.

Recently, I attended a component society meeting where I listened to member concerns, and these were very real concerns, about our relationship with the Blue Cross/Blue Shield, Neighborhood Health Centers, and Medicaid reimbursement. Only the Neighborhood Health Center dealt with quality of care; the others were income-related. When I asked twice for help with the helmet law petition effort, I came up with only two volunteers. I was told that this was the largest crowd to have attended that component society meeting in some time.

*Ray S. Schwarz*

## OUR COVER

August Lenox turns once more to the frontier doctor for this month's cover. Lonely conqueror of disease and physical distress, the frontier doctor is led by duty to ride by dead of night with risk of self to apply his knowledge to the ailing. Painter Lenox knows the West; he was born in a sod shack in Midway County, South Dakota, where he started drawing and storing memories of such early day physicians as that notable gentleman on Our Cover.



## Final Standing of Health-Related Bills Before the 1980 Legislature

Physicians and legislators talking the same language - this is what lies in store for participants at the third CMS legislative seminar. It promises to be a learning experience for everyone involved, a way to communicate with legislators who are foes, and a chance to correct misunderstandings on a golf course or a tennis court or a dance floor or at a dinner table.

Presidents of component societies, specialty societies, and public policy chairmen have been invited. Representatives from the Board of Trustees, members of the Council on Legislation, and physicians serving as liaison members to that council will also be there.

The words "cost containment" seem mundane, repetitious, overused to physicians, but they are red flags to legislators who are badgered from all sides by constituents questioning high medical bills, slow and low payment by insurers, and non-availability of medical services.

Physicians know the role of government, malpractice premiums, new technology; legislators either don't know or need reminding. Physicians know that services performed by allied practitioners are at least as expensive as true medical services; legislators have been told the opposite by everyone of those allied groups.

Finally the subject that neither a physician nor a legislator wants to face rears its head - the rationing of health care. Congressman Wirth recently mentioned, while touring Children's Hospital, that whenever he votes on a cost containment bill he remembers taking part in a Denver Medical Society task force meeting where the ethics involved in "Who Shall Live" were discussed. He avidly recalls the names of most of the physicians present, exactly where he was sitting, and the array of emotions that he felt. We hope to stir some of these same emotions in Vail with a panel composed of tertiary care physicians and legislators who have had personal experiences with critical illness.

"Cost containment" becomes more frightening to all of us in these days of inflation, and any insurance salesman will tell you how frightened every person is about the big health care catastrophe that might hit his family. May 23rd to the 25th promises to be a big weekend - a perhaps combative weekend - but a truly learning and fun weekend for all involved. We are looking forward to it.

### *Air Pollution*

The Senate and House again failed to agree on the method of controlling automobile air pollution, and a conference committee hopes to find a compromise position by the time the legislature meets on May 7th to consider any final actions or vetoes.

### *Arthritis*

Although the arthritis education bill was killed in February, \$30,000 was put in the long appropriations bill for the University of Colorado Health Sciences Center to begin just such a project.

### *Child Abuse*

Two child abuse bills were defeated — one requiring full disclosure of records and one developing a public school educational program. Those bills speaking to the degree of evidence required when separating a child from his parent or guardian, distinguishing the criminal penalty when abuse results in death, and broadening the definition of abuse were passed.

### *Cost Containment*

The bill exempting from sales tax the sale of numerous devices necessary for the treatment of illness, injury, or disability was defeated as a bill but added to the omnibus tax relief bill with a price tag of \$500,000.

### *Medically Indigent Insurance*

All four of these bills were killed, two of them early and the two big ones in truly the eleventh hour — at 11:02 p.m. and 11:04 p.m. on the final night of the session. They became labeled as "Denver General relief bills" and simply couldn't muster the necessary votes in the rurally controlled Senate Republican Caucus. The long appropriation bill's line item for medical indigency was increased from \$10 million to almost \$13 million dollars.

### *Parking for Handicapped*

Both bills were passed granting special parking privileges to handicapped persons other than those with mechanical devices.

### *Physician Salaries*

Physicians in the state personnel system received an increase in maximum salary to \$58,500.00.

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## executive report

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"Dear Mr. Bowman — I just got sued! I am a member of my county society, in good standing. I support my Medical Society by serving on the membership committee. I also serve as a volunteer on my hospital credentials committee. I'm involved with the Boy Scouts and the Chamber of Commerce. I'm a good guy. Recently a physician new to the community applied for Medical Society membership. To make a long story short, our committee decided not to vote him into membership based on his cloudy past. The next thing I knew, I was sued! All I was trying to do was help my Society do my share. Well, I quit. I'm not going to spend my time and money getting sued just to help the Medical Society. Can you help? Dr. Nice"

Dear "Dr. Nice":

1. Don't panic.
2. Anybody can sue anybody, particularly in today's world, but sometimes the judicial system goes awry and there is a total miscarriage of justice — but this is rare.
3. Although there is always risk, it has been exaggerated. *BUT* you have a lot of built-in protections:
  - a. Medical Society, hospitals, the state legislature, and your professional liability insurance all provide different mechanisms to protect you in a variety of settings.
  - b. Members acting on behalf of the Colorado Medical Society review committees have immunity if the physician is "reviewing and evaluating the quality of care being given

patients by any licensed physician," or when reviewing a physician's professional qualifications. This includes membership committees, grievance committees, peer review committees. Physicians doing Foundation (PSRO) review have immunity. Our Hartford Professional Liability Insurance (and most other insurance professional liability contracts) includes an immunity clause for you when you are acting on behalf of your professional organization. Hospitals provide similar protections.

4. Notify the Medical Society, Hospital Association, your attorney, and the broker of your professional liability insurance, or whomever is appropriate, with all the details. You'll get much good advice and counsel.
5. Stay on the committee. Although suits are inevitable, physicians also have an obligation and responsibility to set standards, review their peers. In our litigious world your suit is not unusual. It is aggravating and time consuming. If you were diligently discharging your duties as a member of the committee, and you operated within the limitations or rules you were to follow in the discharge of your duties, things should work out. If you allow due process, and document your actions, your exposure will be minimal. However, if you or your committee members acted maliciously, you could be subject to additional "punitive damages" from which there is no protection.
6. You should be aware of an opposite possible situation. The profession is charged by government and by the public to police itself. (This is preferable to non-professional or consumer organizations setting professional standards for Medical Society, hospital membership, peer review committees, etc.) Failure to set standards or failure to discipline or restrict known physician offenders may also result in legal action.

"Dr. Nice," the message is: Organized medicine at all levels is providing more and more protections in order that you can carry out the purposes of your professional affiliations. Lawmakers in every state have also been sympathetic. Most states have and are enacting legislation to help you. Insurance companies have long recognized the need to protect their insured and the medical organizations with which they work.

Therefore, you have more going for you than ever before, but don't be intimidated. Your professional obligations are a necessity and more important to the preservation of medicine than ever before!

*Rob Bowman*



# at press time ...

## ANNUAL SESSION PLANNING UNDER WAY

The yearly exertion to produce outstanding programs during the Annual Session of the Colorado Medical Society, September 24-27 at the Broadmoor Hotel, is now under way. Intentions are to create a strong series of programs which will continue to meet the high standards of scientific discussion which has marked past meetings.

The Educational Program Planning Committee has been meeting regularly, under the direction of its, Chairman, Pat Moran, M.D., Grand Junction. Members are Terrance Kelley, M.D., Glenwood Springs; John M. Connolly, M.D., Denver; Ray Painter, M.D., Grand Junction; Dean Girard, M.D., La Junta; David Steinman, M.D., Denver; W. Gerald Rainer, M.D., Denver; Rachelle Kaye, PhD, Denver; and Mrs. Patrick (Kathy) Thompson, Fort Morgan.

Polling opinions of previous scientific sessions has led to the concept of a series of 45-minute presentations of which at least 15 minutes will be devoted to a group discussion and questions and answers. This is the type of program most favored.

Two workshops will be presented concurrently on Thursday morning, September 25, starting at 8:30. One session will deal with atherosclerosis, its prevention, the relation and importance of Antithrombin III deficiency and hypercoagulable states, and the recognition of cerebral vascular disease.

A second workshop on infections is planned for 8:30 a.m., also running until noon. This workshop will consider, among other matters, obstetrical infections, their prevention, and the increasingly ominous spread of hepatitis.

Two afternoon workshops, from 1:00 to 4:30 p.m., will consider the two topics of Computers in Medicine and Practice Management. The former will be a discussion of computers in the management of cardiac problems as well as in ambulatory practice management, hospital management, hospital business and patient management.

Friday morning sessions, from 8:00 to 10:45 a.m., will focus on updated presentations for twelve various topics, including management of chronic obstructive pulmonary disease (COPD), joint replacement surgery, Reyes Syndrome, thyroid disease, management of the obese patient, and drug use and the elderly, with other topics to be added.

#### REVIEW SHOWS RETURN OF ANNUAL SESSION TO BROADMOOR A POPULAR CHOICE

Colorado physicians and their families have long considered the Broadmoor Hotel and meeting facilities among the finest anywhere in the world, and this year's Annual Session in September will mark the latest of many annual meetings held there by Colorado Medical Society. New emphasis, however, has been placed on this year's meeting agenda and scientific sessions.

In the scientific education arena, present plans call for a variety of subjects to be presented in the format of a number of "mini" sessions of 45-minute length, including a 15-minute question and discussion period. These presentations are being planned to emphasize information of special interest to the primary physician. Many of the speakers will come from outlying areas of Colorado.

Geno Saccomanno, M.D., Pathologist from St. Mary's Hospital in Grand Junction, has been named to give the Lanning E. Likes Memorial Lecture at 11:00 a.m., Friday, September 25.

As in the past, participants in the scientific programs will be able to earn 12 hours or more of AMA Category I, at no out-of-pocket cost.

The Colorado Medical Society Auxiliary and the Colorado Medical Society Council on Legislation will also have programs, tentatively set for Thursday.



Meetings of the House of Delegates are now scheduled for Wednesday, September 24, at 9:00 a.m., and on Friday, September 26, at 1:00 p.m. Reference Committee meetings are, at this time planned for Wednesday afternoon.

Major social events include the President's Reception in the West Patio on Wednesday evening, the dinner-dance in the main dining room Thursday evening, preceded by cocktails by the Lake Terrace Pool.

An excellent program is in the making, so this is the time to lay your own plans to attend the Annual Session, September 24th through the 27th. Watch for further details in COLORADO MEDICINE issues, but don't wait to make necessary reservations and plans to attend.

#### MEETING FOR COMPONENT SOCIETY PRESIDENTS, PRESIDENTS-ELECT AND MEDICAL EXECS

On Friday, June 20, 1980, Colorado Medical Society Board of Trustees will host the the first bi-annual meeting of Presidents and Presidents-elect of the component societies, joined by staff members of those component societies, at the Denver headquarters of Colorado Medical Society. The purpose of this one-day conclave will be:

- An "update" of CMS current activities and programs.
- A discussion of new and proposed services offered CMS members and component societies.
- A review of the proposed draft Colorado Medical Society By-Laws.
- A workshop on common interests and problems.
- Dialogue to give direction to the Colorado Medical Society in developing future plans.

Colorado Medical Society Board of Trustees are continuing their efforts to make the society responsive to the needs of the component societies. This meeting will be one of the most important of the year. Presidents, Presidents-elect, medical society staff, and CMS Board members should SET THE DATE OF JUNE 20 NOW!

If you have any questions, please contact the executive offices of Colorado Medical Society, 861-1221, Or 1-800-332-4150. Invitations and reservation forms have been sent. Please return the reservation form as soon as possible.

#### LAST CALL FOR RETURN OF CARDS FOR PHYSICIAN'S DIRECTORY LISTINGS

The editors of the 1980 Physician's Directory are getting more than a little frantic now, since two deadlines have already passed, and a third is fast approaching. In the March issue of COLORADO MEDICINE you received a return card on which we asked that you up-date your personal practice information, as you wanted it to appear in the 1980 Directory. We must ask you again to go to your pile of unread material, seek out the MARCH 1980 ISSUE OF COLORADO MEDICINE, extract the postage-paid return card, complete the questionnaire and drop it in the mail AS SOON AS POSSIBLE! The editors are striving to publish the best-ever Directory of Physicians, but that can't possibly be done without your vital information. The Directory is quite important to allied health care agencies, referral service, fellow members of your profession and many others. Please help us to help you.

#### ANNUAL WESTERN COLORADO FITNESS FESTIVAL

The Fourth Annual Western Colorado Fitness Seminar will be held in Grand Junction on June 20-21 at the Two Rivers Plaza Convention Center, under the general sponsorship of St. Mary's Health Education Center. This Grand Junction session will inaugurate alternation of sites between Grand Junction and Montrose, where the previous seminars have been held.

Two nationally known speakers will take part. Dr. George Sheehan, well known for his own running as well as his writing about running, will be joined by Covert Bailey, author of "Fit or Fat." Dr. Sheehan is also a member of the Department of Electrocardiography and Stress Testing at Riverview Hospital, Red Bank, New Jersey. Covert Bailey is the Director of the Bailey Clinic for testing for body fat and physical fitness. Bailey received a Master Science degree in Nutritional Biochemistry and Metabolism from the Massachusetts Institute of Technology. Various booths will be dedicated to the aspects of exercise and nutrition which lead to optimum health and well-being.



# Risk to self, patients, and profession

## *Physician Health Problems*

John R. Graham, MD, Albuquerque, New Mexico

### **Introduction**

A current advertisement for Antabuse shows a picture of the actor, Patrick O'Neal, seated at a table by an upturned glass. The headline reads: "You've been lied to, Doctor... by the alcoholic."

The advertisement goes on to state that "denial is a symptom of the disease of alcoholism," and that in his case, Patrick O'Neal, did not recognize what was going on with himself, and further suggests that perhaps doctors didn't know either. In short, he states that he lied to his doctor, to his family and to himself. The advertisement adds that the medical profession has a fantastic opportunity - to heal, to save lives, and to preserve the quality of lives - by seeing what's really the truth, and having the courage to confront the patient with it.

There isn't anything new in the advertisement. We know that denial is a central dynamic in the problem of alcoholism. However, I introduce this matter to point out denial is a primary dynamic in our difficult health problems within the medical profession. We've all encountered someone who with the problem of alcohol, drug abuse, or major psychiatric disorder is a risk to self, to patients, and our profession.

There are many factors that lead to our avoidance of major trouble within our own profession, and the physician is the first one subject to denial in himself.

So what's new? A recent study<sup>1</sup> reported on screening for drug and alcohol abuse in a general medical population. In a series of one hundred fifty consecutive, first-visit, general medical patient visits, a simple and inexpensive screening procedure was combined with personal inquiry and physician examination for drug and alcohol abuse. 11.3 per cent of the patients were using psychoactive drugs, and 6.7 per cent used drugs or alcohol on a daily basis to the point where the patient himself described his abuse. When confronted with this information 70 per cent of the drug and alcohol abusers

recognized the problem, and subsequently sought treatment for their disorder. The implication is that if one confronts disorder, not only will there be a high degree of cooperation, but there may be a high likelihood of successful outcome.

There are widespread problems among our general medical patients. Psychiatric patients have always used a number of drugs. Epidemiological surveys have shown higher than expected numbers of individuals taking a variety of medications. Studies of alcohol use in the general population have suggested that 5-10 per cent of our population have a serious problem with alcohol.

And what of physicians? Are we immune? Are we part of the general population with comparable statistics in regard to drug and alcohol use? Do we avoid confronting our patients and ourselves?

### ***Hidden from View***

A variety of studies suggests 10 per cent of all physicians have health problems interfering with effective work. If you think about your own community and take a conservative estimate of the number of physicians and the following statistics, you may start to approach some idea of the problem. Though the upper range for alcoholism is often stated at 10 per cent, take a conservative estimate of 6 per cent of the population. How many physicians will that suggest have serious problems in your community? Studies have suggested that 1-2 per cent of physicians are involved in drug abuse. We do not have good data on severe depression. However, you are aware that suicide rates for physician populations are much higher than the general rates for the nonmedical populations. Behavioral problems are another significant issue. Have you ever run into a doctor who seemed disagreeable? Divorce and marital discord are very significant issues. Perhaps you know of someone who is having marital problems. And

the hard driving, pushing physician, who is providing more patient care, but enjoying it less, doesn't get reported as a statistic, but is ever present. And behind the doors of our various offices there is no way to assess the variety of ethical problems that can arise because of high levels of distress within physicians.

One of my physician patients shared an interesting observation recently. The report centered on a physician who was expressing great anger toward another doctor in the community. The physician voicing his discomfort stated the basic complaint about the doctor not being serious in his approach to work. The criticism had been prompted by an incident that demonstrated the physician under attack had learned to do something nonmedical that was quite enjoyable. My physician patient observed that the angry colleague was obviously envious of the other guy who was able to have fun. That's the way it usually is. A physician having fun and enjoying life stands out from the rest of the crowd. A physician in distress goes underground. As a group, we physicians tend to hide our personal problems - generally by working harder. Initially, the family will feel it. Then our friends and colleagues will find that we are unavailable.

The distressed physician seems unwilling to confront problems, especially problems that involve a loss of control and that threaten to disrupt things. In that sense the denial and concealment alter physician behaviors. The fear of reprisal, loss of professional position, economic issues, and an unwillingness to disclose any inadequacies may make us unavailable or detached from our colleagues when we are distressed. The physician in trouble withdraws, in a protective fashion. Hospital practice may drop off and there will be decreasing participation, and finally an avoidance of professional meetings. Isolation. Then, tragically, the physician with problems will come to the surface and out of the isolation, when a final triggering event such as a criminal charge, threatened loss of license, suicide, or bizarre and unprofessional behaviour, brings the impaired physician to a total halt.

### ***History of the Present Illness***

Most studies of pathology are frozen sections at a given point in time, cross-sectional cuts. A man of 44 dies of myocardial infarction, secondary to coronary artery thrombosis, due to ar-

teriosclerotic heart disease. The focus is on the end product, with factors related to a 44-year history of developing arteriosclerosis fading in the background. The basic question of why this individual *develops* the disorder over an extended period of time remains. Physicians are stressed. Physicians decompensate. So how far back do we go in eliciting the history of the present illness?

We should go back at least to the house officer stage. Do you remember those days when you were on call every other night? Those were the glorious days of sleep deprivation, problem with authority figures, control struggles, and dealing with having more responsibility than skills in the management of clinical problems. The difficulties that the practicing physician of today had are no different than those of the current group of interns and residents. A recent survey of Family Practice residency programs<sup>2</sup> indicated the most common problems of residents were emotional illness; marital problems; economic problems, drug abuse; and alcoholism - in that order. The residents surveyed "believe the seeds of impairment are nurtured during medical school and residency training when young physicians may be overwhelmed with long hours, low pay, and lack of support from their peers and superiors." So the History of the Present Illness has to go back at least to the medical school setting. Those were the good old days!

A number of studies on medical students that have been reviewed<sup>3</sup> report on emotional difficulties within the population, and a prevalence of disorder ranging from 6 per cent to 48 per cent. Unfortunately, the studies do not share standardized criteria defining illness. However, the data are worthy of attention. For example, a 1968 report by Simon (see Graham<sup>3</sup>) reviewed 163 deaths from 50 medical schools; the leading causes were accident, suicide, and malignancy. All mortality rates for medical students were at a higher level than the general population.

Well, everything has a history. Medical schools select the high drive, performance-oriented individual, so our history has to start even earlier. Figures on severe emotional disorder in university populations confirm the prior history. As a matter of fact, some research suggests predictive indicators of mental illness in higher education can be developed. Kidd in an interesting study done at Edinburgh (see Graham<sup>3</sup>) found self-declaration of illness related very closely to the prevalence of disorder



in his cohort of 1555 students. Medical histories, consultation rates during the preceding year, capacity for general adjustment in broader aspects of school life, and lack of participation in extra-curricular activities were significant factors. Kidd found prevalence of disorder higher in women than men - 14.6 per cent compared with 9 per cent. Women from broken or unhappy homes were more vulnerable.

But could there be anything that occurs before college as suggested by coming from a broken or unhappy home? The research of Valiant<sup>4</sup> and his colleagues suggest the answer to be yes. They studied 47 physicians over a 30-year period. Their study noted a possible link between the doctor's altruism at a current level of functioning and the early formative years of the embryonic physician. They suggest the need to be giving to patients may compensate for something not provided to the physician in early childhood.

Indeed, I could paint a general picture of the background history of many physicians. This description might possibly fit the reader. The proposal is made that the developing physician is often raised in a home where father is viewed as a very powerful but distant figure - someone the developing physician is not close to; while mother is viewed as a warm and nurturing individual, available, perhaps even indulgent. And not surprisingly, you and I as physicians end up in a position or providing, nurturing, caring for the sick - like a good mother.

What I am suggesting is probably quite clear, and in no way amateur psychology. The presenting problem with the impaired physician, just like the life situation all of us function in today, is a reflection of what has gone on before, what characterizes our way of thinking, feeling, and behaving. We have been shaped by our past, and significant life events from our earlier years are a present day force for health or illness. As Leopold Bellak has stated, "history is the present status of the past."

## ***Stress Management***

None of us like to be distressed. It upsets our delicate equilibrium. Consequently, we have a variety of technics that we use to avoid distress, usually trying to stir up dust and put it behind us. At a meeting in Reno, Nevada, some years ago, the late Paul Blachly, portrayed an interesting concept of "hustle" which I have found

most helpful. When in distress we will hustle up something to get us out of our distress situation. It's usually a high peak activity, an action, to move us ahead. Having a cigarette, taking a drink, entering into an affair, or making a change in professional career from one specialty to another, may serve as examples of "hustle." There's no doubt about the fact that it provides relief. Having a cigarette allows one to sit down, inhale and get things out of one's thoughts. Having a drink is a lovely depressant that helps us to settle down at the end of a busy day. There is nothing more effective as an anti-depressant than an extramarital affair. Changing a career means that you can get rid of all of the old problems associated with your prior professional practice, and enter into some new field where there is less demand.

However, there is also a punishment, generally a long-term drawn out process associated with all of the hustles we engage in. For example, smoking leads to a higher incidence of bronchogenic carcinoma and heart disease. The alcohol leads to very severe problems in regard to liver, heart and brain disorder. An extramarital affair gets to be impossible, because both lover and spouse want you. And a change in career means that you have run into the same types of problems again, except now you don't have any seniority. Most of us end up with the sense of punishment raising a question: Why is life treating me in such a shabby way after I've been such a nice person?

But there is no doubt about the hustle having been helpful in regard to reducing the initial distress. Indeed, it's so far removed from us that we don't even know what it is. But herein lies the fundamental paradox. When caught in the hustle to manage stress, we have no opportunity to change the basic distress confronting us. Thus, it's as if we had placed our life on automatic pilot, and in the process of fooling ourselves of getting into control, we, in fact, have simply given up control of our own life situation.

## ***Critical Points for Decompensation***

We live with many myths. We are high-drive, performance oriented people, and we often find ourselves caught in a trap, as if the system has hustled us. Society avoids direct contact with sickness and death. Society finances the training of a select group to manage the sick and research the disease process. The public myth

involves mastery of all problems. The public expects their professionals to be immune to illness, available at all times, competent in an increasing number of technical fields, and to possess a rich combination of personal warmth and composure when disease and illness occur.

The great hazard within the health professions is acceptance of the ability to alter the course of destiny. One is predisposed to assume the myth by virtue of personal need, the process of higher education, and a variety of societal reinforcements. Through a series of learned behaviours we become trained practitioners, deconditioned to the usual symbols of pain, despair, and disease. Successful graduates of the system run the risk of playing a game that must be lost.

And herein lies the fundamental stress - the process of distancing oneself from the human, innate response to sickness and death. There is a potential masquerade of accepting the unrealistic, of being too much too soon, of maintaining an image of what society wants, and what, in fact, the physician cannot be. Thus, during the training program we find ourselves growing away from the typical response the public will have, as we become a specially trained group.

Following training, the young physician will add to financial worries with further debt while establishing a practice. By this time there are further responsibilities in regard to a marriage and a growing family, and the physician will come home at the end of the day "having already given at the office," and now be asked for a piece of whatever is left. There also is the remnant of the old competitive drive, the need to be better than adequate. Thus, as one gets established in practice for five or ten years, a concern about the newer, younger, brighter graduates on the market place may start to develop. And by age 40 the physician will start to question things. There are many doubts about the commitments that have been made in professional and personal life. It's at this point that parents often die. The children are getting older. Unfortunately, the physician in his busy practice doesn't have a chance to get away for a nice vacation, but at least has enough money to provide the children with a trip to Europe, attendance at a nice school and other matters, which though stripped of the personal interchange with the parent, seem to be a good substitute and a background for living. It's in this

context that marital discord may be present. The spouse often is not the good mother that was always wanted. The office overhead goes up again. The person in the office who was doing such a good job in handling all of the third party collections, decides there's better grass on the other side of the town. Patients die. And then you say: Is this all there is to life?

But that's a dangerous question. It raises distress and upsets the delicate balance. It's time to hustle. So let's get busy and work, be with the patients who really need us. One of my physician patients decided that full-time work was too stressful, and took a half-time job. In this sense the half-time job was 35 hours per week, and one or two nights on call.

The denial and avoidance means we buy into the myth. Our resistance to a realistic appraisal goes up. We become more secretive, isolation may occur, and as studies of drug and alcohol use<sup>5 6</sup> have shown, we are predisposed to decompensate at a point removed from graduation. The average age of the drug-abusing physician is 43. After being in practice for about 18 years, and using drugs for one or two years before discovery, the physician is in trouble. The alcoholic physician is a little older, perhaps about 48 years of age, because alcohol is so acceptable within our society, and more readily hidden from view.

## *Recognition of Distress*

The most complex issue in this whole process has not to do with the development of the problems so much as the identification of the physician having difficulty. Theoretically, there must first be a responsibility to one's self to get treatment for the major problems that lead to physician impairment. However, denial and avoidance are the enemies within, and it is rare that the physician will tolerate a confrontation with self, and seek treatment. Generally, a partner in a marriage, a colleague, a committee or some other problem will alert the physician. Even under those circumstances physicians seem resistant to the idea of getting help for themselves. The high drive, performance-oriented physician is not ready to admit defeat. Thus, a second line of defense should be on the collegial level where we are brothers, and share a responsibility for each other. Here again we run into the problem of denial where it is difficult to see problems in one's self, and, there-



fore, they're often avoided in colleagues. There is a built-in reluctance to "blow the whistle" on someone. Further, few of us are trained to confront someone. There are countless stories of physicians who, having recognized their problems and responded well to treatment, admit that they would not have been able to listen to a warm and understanding colleague attempting to offer assistance.

Committees in hospitals have a very real responsibility to protect their patients. Indeed, there are some suggestions and some legal precedents now which place the practicing staff in a hospital at risk when one of their colleagues is not performing at an effective level. Many of you are aware that committees with responsibilities in hospitals often smooth over or avoid serious problems. It is as if confronting someone seems improper when just the reverse is the case. Occasionally, there may be grievances from the public that come to a county medical association. Government officials will identify the physician who prescribes excessive amounts of narcotic. Unfortunately, most physician impairment problems quickly go to the issue of licensing with the state licensing board usually being the agent identifying a problem. By that time the game is lost.

Suspension or revocation of license to practice is the most potent factor in making for change in a physician impairment problem. However, it would be nice if there could be some intervention before that, intervention that is appropriate, effective, and allows the physician to benefit from treatment while staying in the active practice of good medicine.

So the task is on all of us. Physician health committees, or committees on the impaired physician that have been established around the country may give the impression of doing something. Whenever we have a problem we establish a committee. There is nothing magical about an anonymous group of "concerned physicians" working within a committee. The responsibility is on each and every physician to be "the concerned one" and open to recognition of problem in self and colleague.

There are some obvious indicators that can help us identify someone predisposed to trouble. A prior history has to be an alerting signal. The hustle behaviors that I have discussed earlier are part of a push to stay ahead of trouble. Entering into an avoidance pact when distressed, usually involves withdrawal, pulling out of the

hospital, not attending continuing medical education programs and being unavailable socially.

## *Intervention*

Intervention has no single best way, no single prescription that works for all disorders. However, there are some general principles which should be kept in mind. When an intervention with someone in distress is to occur, there should be collection of material that documents what is happening. Idle comments, offhand corridor remarks or poorly planned meetings don't work. In general, a one-to-one contact is ineffective, because the physician in trouble can simply laugh it off or falsely reassure a colleague. In general, we can maintain an effective working relationship with a distressed colleague when more than one person is involved, initially meeting in the physician's office, later monitoring the ongoing course of events, and, therefore, supporting each other in the shared concern for the distressed colleague.

Being direct and involving the spouse and family members is certainly an appropriate strategy. Frequently, the family members are left out on a limb, often cut off from any access to an understanding connection with other physicians. There certainly is adequate justification for a physician health committee to educate physicians and their families, to be available as a counselor whenever appropriate, but never to buy into the myth that a committee will resolve such a complex and distressing problem as the physician in difficulty. There is a balance between warmth and firmness which has to be established. Though, I don't have any clear cut recommendation that will serve all situations at present, there is some suggestion that those programs in which the ability to practice medicine may be restricted, add punch to a proposed treatment program.

If a physician is having problems and is making some attempt to get treatment, there can be no blame. Indeed, that is a situation that naturally lends itself to a positive reinforcement. However, when a physician is in trouble, confrontation has occurred, and no attempt is made to seek treatment, the situation remains out of control. It is at this point that something beyond warmth is needed: The physician with a severe problem who continues to deny the existence of the impairment is predisposed to more trouble. As a profession we do no service to someone in

this situation. It is analogous to someone having diabetes who simply refuses to take his insulin, or a thyroid patient with dysfunction who states he does not choose to take his medication to correct a problem. If that is our patient, we have to challenge him, and ask for some compliance with realistic approaches to treatment of disorder. So, too, with the physician who is out of control.

The role of the physician health committee is not one of being a policing agent, a punitive or threatening body that will restrict physician practice. Any county medical association that establishes a physician health committee has declared a concern about a realistic problem. Such a committee has as its primary task, education. There can be advisory or counseling activities, which map out treatment alternatives when a physician problem is identified. A physician health committee does not attempt to offer treatment, but does offer assistance in getting a distressed physician to an appropriate treatment resource. In this sense, there is a

cooperative set of colleagues, available to the distressed physician who have a specific understanding, concern and experience with problems. The primary attempt is one to prevent and anticipate difficulties, and to work on a voluntary basis, getting somebody back into control of his own life where self respect, professional integrity, and clinical competence are developed to the fullest extent before the problems go underground, and ultimately turn up on the surface with a physician in stress, now advanced to the physician in trouble where external forcing factors demand change.

The impaired physician is a loss to self and to us as a professional group. We have our work cut out for us. The first task involves the accurate identification of problems and the recognition of distress, and that's a shared task we cannot deny, a shared task we cannot avoid. ●

For reprints: John R. Graham, MD, Medical Director, Albuquerque Centre for Psychotherapy, P.A., 7107 Prospect Pl., N.E., Albuquerque, New Mexico 87110. Dr. Graham is also Clinical Professor, Department of Psychiatry, University of New Mexico School of Medicine.

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## CME Workshop Report

Workshops on how to run CME programs were given in late March at St. Mary-Corwin Hospital, Pueblo; La Junta Medical Center, and Ft. Lyon V.A. Medical Center. Sponsor of the program was the Southeast Area Health Education Center, a component of the UCHSC SEARCH program. Workshop topics included:

- How to identify educational needs in the community hospital
- How to be better at CME teaching
- Making and using visual aids
- How to evaluate the teacher - and the learner.

The three workshops were coordinated by Stanley Bailey, MD, Medical Director of the Southeastern Colorado AHEC. The faculty team consisted of Clyde Tucker, MD, Director, Office of

Educational Services; Ricki Bronstein, PhD, and Leslee Swendsen, PhD, Instructional Consultants - all of UCHSC, and Kevin Bunnell, EdD, of the Colorado Consortium for Continuing Medical Education and the Colorado Medical Society.

Local coordinators for the workshops were: St. Mary-Corwin, Dr. Bailey, Fort Lyon, Kenneth Russell, EdD, and La Junta, Dean Girard, MD.

Physicians interested in sponsoring a similar workshop for their hospital staffs should phone the Director of the Area Health Education Center near them, or call Dr. Clyde Tucker at UCHSC, 394-7307.



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## Hospitals Amidst the Credit Crunch

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guest  
editorial

Editor's Note: In the April 7, 1980, edition of the *Wall Street Journal*, an editorial titled "The Next Victims" caught the attention of many of Colorado's physicians. The subject deserves the attention of physicians and economists, alike, dealing with the future or the plight of the voluntary hospitals. Excerpting from this editorial, *COLORADO MEDICINE* took the case to Colorado voluntary hospital operators, aka Colorado Hospital Association. Hereafter is a capsulized presentation of that *Wall Street Journal* editorial, a sobering view of only one aspect of the effect of our present money crisis:

*Wall Street Journal* editors have been watching for the next victims of the "coming credit crunch, and on that list of potential victims appear the voluntary hospitals of New York. The Journal observes that "Hospitals across the country are facing severe budget trouble, thanks in good part to federal regulation, but in New York their problem is compounded by a horrendous cash flow crisis. Red tape has so snarled their Medicaid reimbursements that they have been forced to double, triple and quintuple their short-term borrowing just to meet payrolls." WSJ further observes that the hospitals' tight medical dollars are being diverted to satisfy debt service, creating a severe threat to continued credit.

WSJ, again, observes that "this crisis began, sadly enough, with the state's effort to modernize and control its Medicaid program through a computerized MMIS (Medicaid Management Information System)." The city reportedly had no way to track over-payments, double payments, and outright fraud, but, as the WSJ says, "the state refused to provide for advanced payment claims." There were arguments in favor of the state's announced goal of getting out payments within two weeks, and there were arguments to the effect that the state was merely trying to protect some of its own cash flow. The company which handled the MMIS says it is still meeting the goals "on 'clean' claims." But, says WSJ, no one anticipated how long it would take to produce a 'clean' claim. "First a new patient has to be declared eligible for Medicaid; the city takes at least two months to get him on its list. Then he has to show that Medicare or private insurance has paid its share." The company handling the MMIS added that 80 days thus elapsed before it received the claim. Hospitals said the delay was closer to 120 days.

So, who's keeping the hospital running in this interim of no cash flow? As WSJ observes, in order for hospitals to meet regular payroll, which consumed 70% of their budget, hospitals have been borrowing and stalling payments to suppliers, one of the worst enemies of cost control. Again, from the WSJ, "One administrator reports paying 20% interest on bank loans which grew from \$3 million to \$15 million, so that added expense now takes \$11 of his fixed \$375 daily room rate." Hospitals are forced to abandon competitive shopping for supplies, which further forces up costs, and "hospitals have no cash to stockpile items in advance of price increases."

*Wall Street Journal* reports that vendors are even demanding cash payments, in some cases, while banks are beginning more restrictive credit lines, with four hospital bankruptcies in New York last year. In addition to this, WSJ observes that "the inefficient municipal hospitals in the city's Health and Hospitals Corporation are the ones which should be closed, but they're insulated from the crisis by a \$63 million line of credit with the city treasury."

In summary, *Wall Street Journal's* editorial writers say the "hospitals are lobbying hard for a state program of advance reimbursement, but it won't touch the basic problem of underfunding resulting from government regulations which limit revenue at the same time as they help boost costs. The situation is an ominous foretaste of the future that lies in federal proposals for hospital cost containment and National Health Insurance."

Does this suggest that the same set of conditions exist in Colorado voluntary hospitals? Could a like situation occur? And if so, what would be the consequences? There is no oracle to whom we can turn for that answer, but Arvid B. Brekke, President, Colorado Hospital Association, provides us this analysis and reaction:

### A Reaction to The Wall Street Journal The Next Victims

Will Colorado hospitals be the next victims of the credit crunch? Perhaps.

But, Colorado isn't New York, and this is an economic blessing for Colorado.

New York hospitals have been facing financial problems for many years. Two reasons: New York's payment methods and overregulation.

A recent New York study showed \$40 of every patient's daily bill is attributed to state and federal



regulation. New York hospitals have been going bankrupt at an alarming rate, even before the credit crunch. Much of this has been attributed to the hospital rate setting commission in New York, which has not permitted the hospitals sufficient cash flow to survive.

Breathe now the sigh of relief. It could have been Colorado. This state's hospitals spent two years under a rate setting commission which, to our very good fortune, was abolished during the last session of the Colorado General Assembly. Thus, a portion of the pressure for economic failure has been relieved.

Colorado hospitals, however, do have a serious concern about maintaining cash flow during this recessionary credit dilemma. For a long time, cash flow has been a problem from patients in Colorado covered by Medicare, Medicaid and, to a lesser degree, Blue Cross. The snarl was due to computer difficulties and it has recently improved. During the problem period, hospitals received payments to make up for the computer-caused problems, so cash flow did not reach the dangerous levels that were possible.

Now Colorado has moved into the federal Medicaid Management Information System (MMIS), and troubles like those experienced in New York have shown up in this state. Colorado hospitals have had to work closely with the MMIS program to prevent slow payment of claims.

Today, hospitals are very concerned about their capital needs, both in buildings and equipment. High interest costs are forcing hospitals to delay improvements in facilities and replacement of equipment. In addition, cash flow problems have caused hospitals to delay payments to supply vendors. For some, these extensions have gone beyond the vendors' ability to extend credit, and collection efforts are underway.

One of Colorado's greatest financial problems, and one which is common throughout the country, is inequity of payment from certain third-party reimbursement agencies. When fiscal intermediaries, such as the government through Medicare and Medicaid, do not pay their full share of incurred costs, other sources must make up the difference. These "other sources" are frequently self-paying patients and commercial insurers, who pay a higher tab. Critics of this method of payment are becoming more vocal and don't want to pay more because other agencies pay less. New York's high percentage of Medicaid patients has heightened their financial squeeze.

Hospital administrators and trustees are concerned about the financial future. Cash flow is an issue, but certainly not of the magnitude we see in New York.

We must be watchful against further regulation of hospitals, already among the most regulated in the

country. And we must take a lesson from New York and make sure payors pay their fair share.

I believe some of the problems foisted on hospitals by the government may be a deliberate attempt to launch a national health insurance program. The government now represents nearly 50 percent of hospital business. If the government is controlling the industry and not paying its share, cash flow problems are inevitable. It is one way to bring hospitals to their knees, but through proper vigilance it is avoidable.

Arvid B. Brekke

President, Colorado Hospital Association

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## new members

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**Denver County Medical Society:** Paul G. Moe, George E. Quick, James V. Winkler, Johnny E. Johnson, Jr., Laurence W. Brooks, Carlos J. Troconis, Thomas L. Rodts.

**El Paso County Medical Society:** Robert E. Cox, Donald D. Cameron, William W. Freedman, Sharon K. Pool, Lloyd L. Strode, Francis W. Fuselier.

**Clear Creek Valley Medical Society:** Helen M. Coates Gerdes, Martha Illige, Robert W. Parker, Joseph Matarazzo.

**Mesa County Medical Society:** Charles E. Roy, James Dale Utt, Robert John Conrad.

**Otero County Medical Society:** Marcia Lynn Collins, Rudolf A. Hofmann, Carol Ann Hunter.

**Pueblo County Medical Society:** Robert S. Hamilton, Jr., Robert Douglas Beekman.

**Northwestern Colorado Medical Society:** Richard W. McGrath, Donald Tomlin.

**Boulder County Medical Society:** Robert B. McFarland, Hartmut Winfried Kolsch.

**Washington-Yuma Counties Medical Society:** Philip C. Brittain.

**Arapahoe Medical Society:** Robert B. McWilliams.

# Rocky Mountain Medical Conference

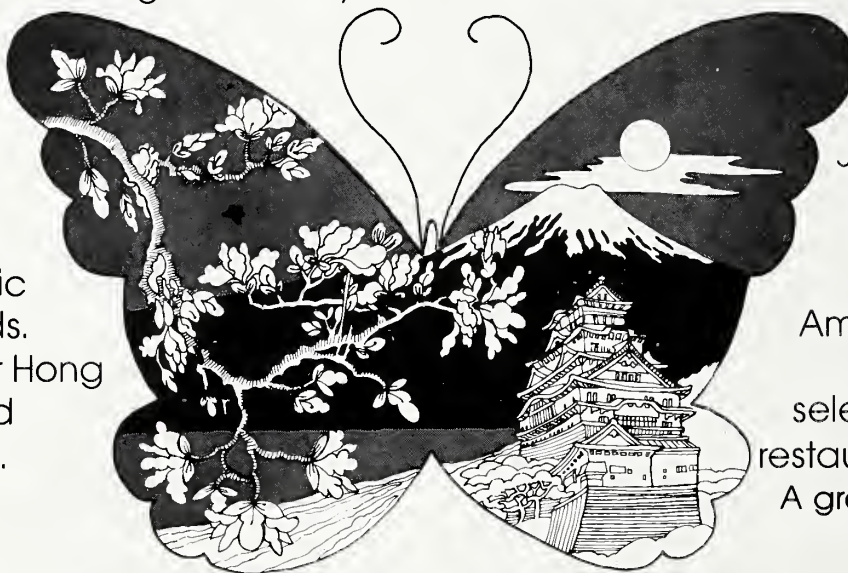
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## Books By Courier

The doctor in Greeley is on the phone in the Denver Medical Society Library in Denver. The ailing patient seems to have hyperglycemia but the analysis is uncertain. The doctor recalls reading an article in *The New England Journal of Medicine* which he had found particularly cogent on this topic. No longer can he find his copy of the article.

At a meeting in the midwest a speaker has referred to studies by a doctor in a specialized field. He calls the Library on his return to Denver. Can he get the book in which the studies are detailed?

Multiple challenges such as these come daily to the Library where the staff uses its vast resources to provide doctors, members of the Colorado Medical Society, with such information in the form of articles, books, and sourcebook listings as they require.

One major way in which such needs are satisfied is by the Central Colorado Library Systems Courier which was established in 1974 for the benefit of CMS members in Adams, Arapahoe, Boulder, Denver, Jefferson, and Weld counties.

Doctors aware of this unique library lending system call as the two above to the Denver Medical Society Library and make their request. If the book

or Journal is available, within two days the book will arrive at a public or college or university library in his community where he withdraws the book using his library card if it should be a public library.

This extension of the neighborhood library to regional dimensions makes it possible for a doctor to stay abreast of significant medical developments. The information retrieval system used here is another area in which the Denver Medical Society Library endeavors to provide needed knowledge to CMS members.

When these doctors call the Denver Medical Society Library they make a point of inquiring as to the closest service point. What materials have been requested will be sent there with a return routing slip. The closest service point need not be a public library. It could be, as stated above, a university or school library.

Next month we will describe alternative methods of obtaining materials for those not so fortunate as to be included in the Central Colorado Library Systems Courier.

**Allen Young**  
Assistant Editor



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(ski trips, softball team, etc.)

"A Day at the Legislature" was a successful outing for a group from Longmont, Colorado, and four other persons who represented Denver-Arapahoe, and Adams County-Aurora Medical Societies.

Lobbyist Carol Tempest, Colorado Medical Society, hosted the day-long visit of seven persons from Longmont, including two physicians, and four from the Denver area, two physicians and their wives. Following their visits to the House and Senate sessions, the group then attended a number of reference committee meetings. The group adjourned to the University Club for lunch, where they were able to talk with members of the legislature.



Carol Tempest visits with Dr. and Mrs. Frank McGlone of Denver-Arapahoe County Medical Societies at lunch, where they had the opportunity to talk with Representative Paul Schauer, (R-Dist. #39) of Littleton.



The Denver-Arapahoe-Aurora contingent included (l to r) Carol Tempest, Dr. & Mrs. McGlone, Mrs. & Dr. James Urban of Adams County-Aurora, Representative Paul Schauer of Littleton and Glenda Chips, CMS Staff Assistant.



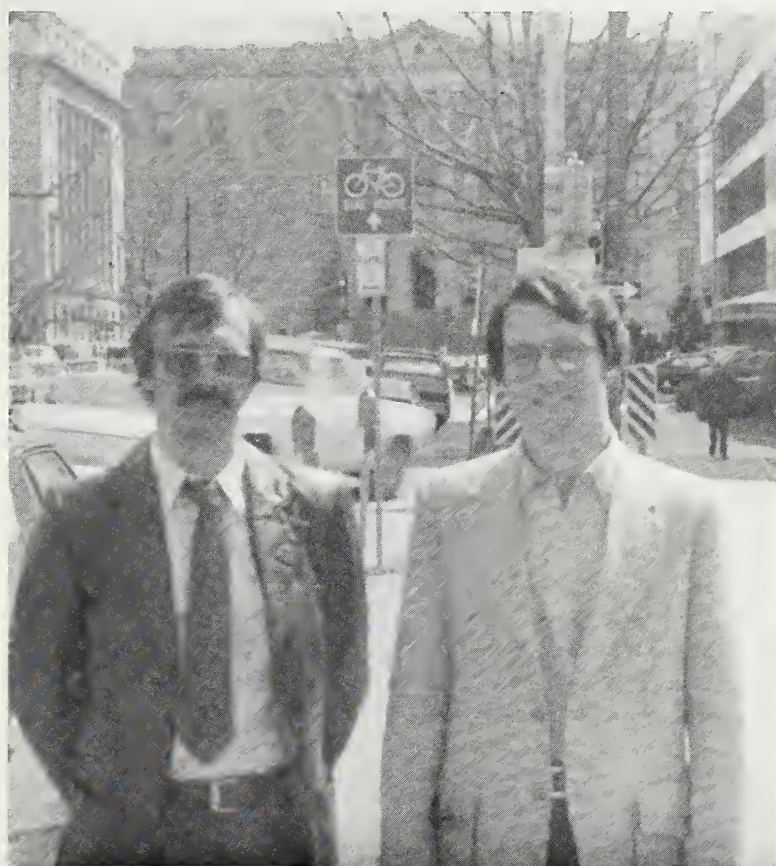
The Colorado Medical Society was well represented . . . and well received when Ray G. Witham, M.D., President of CMS, presented a check for \$3,055.40 to Ron Kahler, President of the Colorado Diabetes Association. The check was one of four such gifts presented state non-profit, health-oriented organizations by the Colorado Medical Foundation. The American Diabetes Foundation, Colorado Affiliate, Inc., is moving its offices in May from 1045 Bannock to 2450 South Downing, across from Porter Hospital.





Longmont Chamber of Commerce Manager Dan Hall hosted the second table for lunch, where his group had the opportunity to talk with Arapahoe County Representative Jim Reeves (R-Dist #38) of Littleton.

Seated (l to r) are Howard Cohen, Administrator, Longmont United Hospital, Dan Hall, Longmont Chamber of Commerce, Rep. Jim Reeves, Mrs. Andree Hall, Mary Bustor and Lori Steffen, both members of the Longmont Chamber Medical Committee, and (with back to camera, Drs. John Glode and David O. Boyer, both in private practice in Longmont).



Drs. David Boyer and John Glode (l to r) from Longmont took part in the day-long visit to the Capitol. Both felt they had learned a great deal about the legislative process since they saw, first-hand, some of the health and medical service problems being dealt with by the legislature. The doctors also visited hearings and committee meetings.

The 1980 session of the legislature proved an interesting study to those physicians who were able to visit the session, the hearings and other meetings. Carol Tempest, CMS lobbyist, hopes that this will be a growing phenomenon among Colorado physicians, to help them grasp the meaning of lobbying, and the necessity of lobbying.

This month, the Colorado Medical Society, Council on Legislation, will be holding a legislative seminar (May 23, 24, 25, at Vail) to further bring legislators and physicians into a common arena of discussion and information exchange.

## Socio-Economics Council to Hear HSA's

Key representatives from the three Colorado Health Systems Agencies and interested CMS members will attend the May 28, 1980 meeting of the Council on Socio-Economics to interchange ideas and information on pertinent subjects. All members are invited to attend. Please call: 861-1221, ext. 267 (Sandy Wendt) or 1-800-332-4150, if you plan to attend.

## Robinson Promoted at NJH

Arthur R. Robinson, MD, genetics expert at the National Jewish Hospital and Research Center, the National Asthma Center, has been named Vice President for Professional Services at the Center.

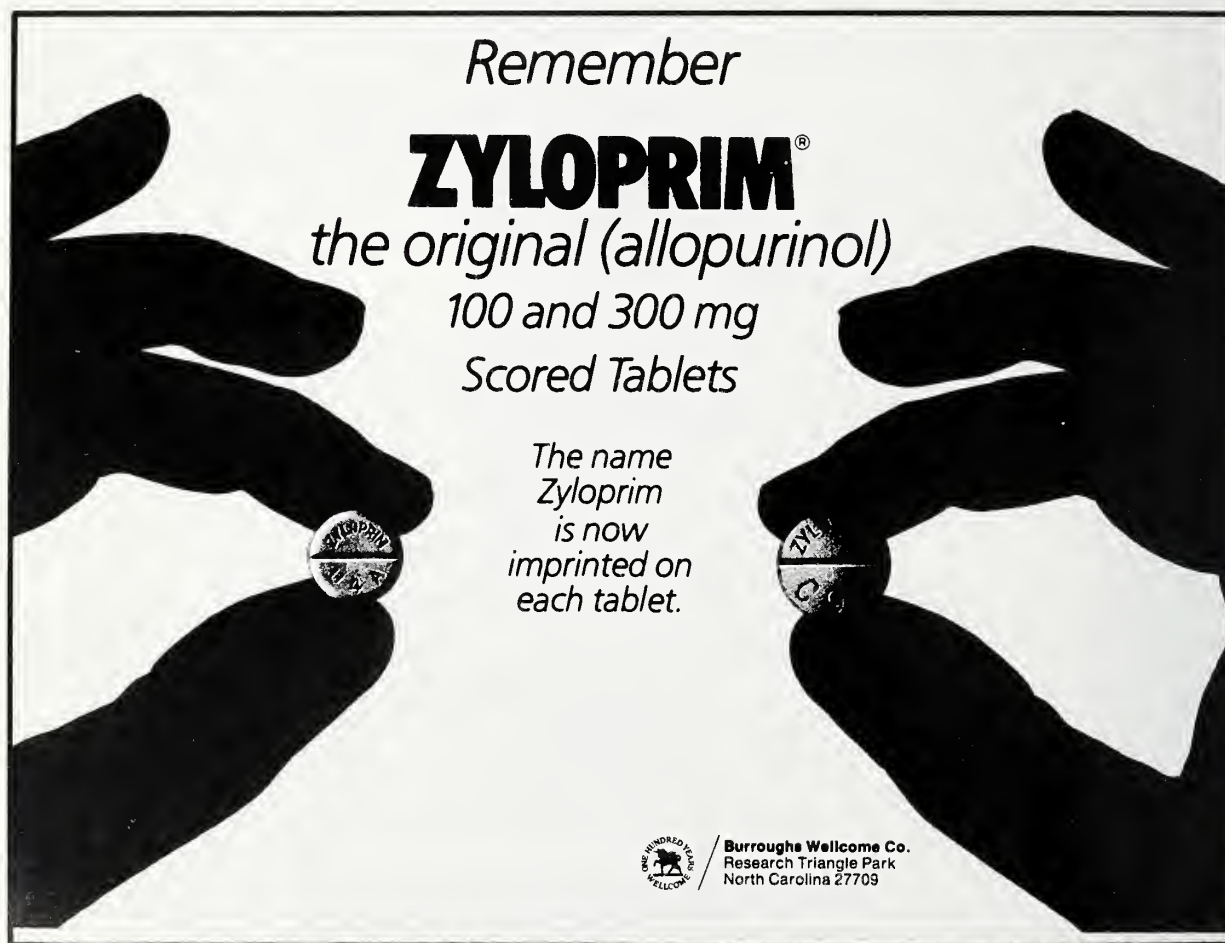
Doctor Robinson joined the Center in 1974. He is a professor of biophysics, genetics and pediatrics at the University of Colorado Health Sciences Center.

## Clear Creek Sponsors Health Symposium

A town meeting on health care in the form of a symposium on the subject of "A Woman and Her Doctor" will be held on Wednesday, May 21 at 7:30 p.m. in the Pomona High School auditorium at 8101 West Pomona Drive in Arvada under the sponsorship of the Clear Creek Valley Medical Society.

Leonard Bernstein, MD, will moderate, and panelists include Margaret Edmundson, RN, Certified Nurse Midwife on "Alternatives in Birthing Practices," Dennis Law, MD, General Surgeon, on "Evaluation of the Breast Lump," Ronald Tegtmeier, MD, Plastic Surgeon, on "Breast Reconstruction," and Dr. Bernstein on "The Pap Smear."

For further information call 429-0701. The public is invited to attend. There will be free coffee and refreshments.

An advertisement for Zyloprim (allopurinol) featuring two large, black, stylized hands holding two white, scored tablets. The text is centered between the hands. The top text says "Remember" in a serif font. Below it is "ZYLOPRIM®" in a large, bold, sans-serif font. Underneath is "the original (allopurinol)" in a script font. Then "100 and 300 mg" in a bold sans-serif font, followed by "Scored Tablets" in a script font. In the center, it says "The name Zyloprim is now imprinted on each tablet." in a script font. At the bottom right, there is a small circular logo with a horse and the text "ONE HUNDRED YEARS" and "WELLCOME". To the right of the logo is the text "Burroughs Wellcome Co. Research Triangle Park North Carolina 27709".

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## Towards a Norm of Good Health

To quote an Editorial in the *New England Journal of Medicine*, "Good news is worth telling and retelling. Age-adjusted cardiovascular mortality rates have declined almost 32 percent over the last 30 years. In the last 10 years, however, the decrease has accelerated precipitously, accounting for over two thirds of the total 30-year reduction, and is seen in both sexes, in whites and non-whites and in every age-decade band from the second to beyond the eighth . . . For stroke the fall (between 1968-77) was even greater, 32 percent."<sup>1</sup>

These are fundamental changes in disease patterns. To what they are attributable is simply unknown, but the association of these changes with major alterations in smoking habits, ingestion of fats, control of hypertension and exercise patterns is compelling.

Increased attention to chronic disease patterns and major new efforts in "health promotion" are part of a phenomenon which enthusiasts have labelled the "second public health revolution." In the terminology used by us and by the Surgeon General in his informative 187-page document, *Healthy People*,<sup>2</sup> "health promotion begins with people who are basically healthy and seeks the development of community and individual measures which can help them to develop lifestyles that can maintain and enhance the state of well-being."

Health promotion thus contrasts with "medical care" which begins with illness, and "disease prevention" which begins with a threat to health, e.g. a known disease or environmental hazard, and seeks to decrease the consequences of the hazard.

Through the Center for Disease Control's Health Education-Risk Reduction grant program, the federal government is emphasizing smoking cessation, reducing misuse of alcohol and drugs, improved nutrition, exercise and fitness, and stress control. Health promotion efforts in these areas can include a variety of strategies including patient and public education, increasing access to adequate diet, and to opportunities for exercise and, in general, creating an environment where positive health practices will become a societal norm.

For an effective, comprehensive approach, health promotion activities can and must be carried out in a variety of settings including schools, private physicians' offices, public health facilities, hospitals, business and industry, as well as community facilities. The opportunities for health promotion or referral to health promotion resources by the physician are virtually endless. In the past, physicians generally have not been aware enough of the resources available to patients interested in changing personal health behavior; we believe this is changing rapidly. Few groups are jogging more and smoking less than physicians. Their personal habits are translating into both good example and informed advice to patients.

Governor Lamm's personal commitment to health promotion is well known, and has become a policy commitment for his administration. The Department of Health, with the help of CDC grant funding for our new Health Promotion and Education program will be able to assist and enhance health promotion activities statewide by serving as a technical resource and a clearinghouse for information on successful programs. During this calendar year, we will be working in several program areas including the development of a risk-reduction data system, an inventory of health promotion resources, programs of professional education/public awareness, pilot programs in adolescent smoking/alcohol intervention, as well as the development of a Health Promotion Consortium which will bring together the array of agencies and individuals working in health promotion throughout the State.

We invite you to participate with us in the development of these health promotion efforts, and we will be happy to share resources and additional information with you. Contact Dr. Tom Vernon, Assistant Director, Office of Health Care Service, or Mary Davis, Health Promotion and Education Section, Colorado Department of Health, 320-6137.

Mary Davis  
Denver, Colorado

### REFERENCES

<sup>1</sup> Editorial, *N Engl J Med*, 300:480-1, 1979.

<sup>2</sup> *Healthy People* - The Surgeon General's Report on Health Promotion and Disease Prevention, Department of HEW, 1979, Publ. No. 79-55071. May be ordered from Supt. of Documents, U.S. Gov't. Printing Office, Washington D.C. 20402, Stock No. 017-001-00416-2. Cost - \$5.00.



## Auxiliary Annual Report

In her annual report to the Board of Trustees of the Colorado Medical Society, retiring President Betsy Becker delineated multiple activities which involved the 1,310 state members and the 1,054 AMAA members of the Auxiliary. A concentration on increasing that membership was listed as a key element of future activities.

The particular importance to the leadership of the Fall Leadership Confluence was stressed in the report, and the relationship of a dues increase to the increase in membership was given full stress.

The Auxiliary was gratified to have its first program in conjunction with the Interim Session at which both seminar and luncheon were filled to capacity. On this occasion the Physician's Survivor Booklet was given distribution. The presence of a member of the nursing profession on the planning committee has made the award of nursing credits possible this past year.

The following councils and committees of CMS have representation from the Auxiliary: Public Information, Public Health, Socio-Economics, Health Education and School Health, Scientific Education and Legislation, an ongoing communications link which strengthens both organizations.

Health Power has been the single most energy-consuming project of the Auxiliary, and it has been a successful operation chiefly because of the fine cooperation of many individuals, including Bill Pierson, logo designers Mary Steinbrecher and Darlene Merkel of Mesa County, the many doctors

who distributed the brochures in excess of 80,000 copies. March was designated Health Power Month in Colorado, and media support of the campaign was important.

The following worthwhile endeavors were accomplished:

1. Governor Richard Lamm and the Mayors of both Denver and Pueblo proclaimed March Health Power Month.
2. More than 80,000 Health Power brochures, listing seven basic health habits were distributed by Colorado physicians, grocery stores, etc.
3. Weekly health tip articles in the Mini-page section of the *Rocky Mountain News*, edited for children, appeared during March.
4. School Health Foods Day and School Health Fairs were carried out.
5. The Metro Council of Auxiliary Presidents distributed AMAA Family Health Records forms, immunization information, and CMS phone numbers.
6. Cooperation with Colorado-Wyoming Restaurant Association on the mailing of order forms for Heimlich Manuever posters on choking rescue. Order forms were mailed to all member restaurants, and the posters were delivered by Auxilians. At latest count, 60 orders had been filled. A booth was staffed by the Auxiliary during the CWRA Convention in Denver.
7. Health programs were carried on during March

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- by Hospital-Auxiliary co-sponsorship, including a special computer survey of auxiliary and employee dietary habits, and some health classes are being planned.
8. Development of a poster contest for Colorado Schools, grades K-12, based on the 7 Health Tips sponsored by the Colorado Public Health Association and the Colorado Department of Education.
  9. Promotion of Health Power by appearances on two popular TV shows: a) Betsy Becker and Kathy Thompson on "Denver Now," March 19, and b) During one full week Health Power was demonstrated on "Noel and Andy" by Auxilian Jan Holman, among others, and four T-shirts were given away daily to children in the audience.
  10. Taped radio spots were distributed throughout the state, with each county auxiliary president receiving a listing of questions to be used in setting up radio interviews with local physicians.
  11. Distribution of AMAA Shape Up for Life materials.
  12. Seminars, sponsored by county auxiliaries and medical societies, on various health topics have been held.
  13. Cardio-Pulmonary Resuscitation courses have been taken by Auxilians and have been promoted in schools for teachers and students.
  14. CMS annual media awards competition for Colorado health articles and programs has been established.
- "Colorado's enthusiasm is high! We hope to make Health Power a way of life in the mile-high state," writes President Becker.
- The AMA-Educational and Research Foundation is an ongoing project. To date, this year, eight counties have raised \$11,468.65 from the holiday sharing card, and \$1,673.63 from other sources.
- The emphasis on cooperation with hospital auxiliaries has brought excellent results with cooperation on several projects.
- All committees have worked hard, and have enjoyed successes as well as some disappointments. Colorado has a very dedicated group of volunteers working for medicine and its future, and, President Becker concluded, "I'm sure they will accomplish more each year. It has been a very gratifying experience to work with this organization and I extend my thanks to all who have donated their time and effort. I'm sure the years ahead will be filled with continued progress."

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# Effects of radiation on health

## *External Penetrating Radiation*

R.W. Bistline, PhD and R.E. Yoder, ScD, Golden, Colorado

*The task of trying to reduce the many volumes of information that have been gained from animal research and human data regarding health effects from radiation is enormous. This article will be limited to the studies of external penetrating radiation and will include a review of both genetic and somatic effects in animals and humans.*

### **Genetic Effects**

The first experimental results linking radiation and genetic effects were reported by H.J. Muller who discovered that radiation can cause mutations. It was not until after World War II that genetic risks to the population were regarded as a major factor in determining maximum permissible doses. Up to this point, emphasis had been placed on the protection of the individual who, for occupational or other reasons, might receive a radiation exposure that would be harmful to himself.<sup>1</sup>

In 1956, The National Academy of Sciences - National Research Council Committee on the Biological Effects of Atomic Radiation (the BEAR Committee) introduced the concept, the regulation of the overall average dose to the population. They recommended that, because of the genetic risk to future generations, man-made radiation should be kept at such a level that the average individual exposure be less than 10 roentgens (R) before the mean ages of reproduction, a time taken to be 30 years.

Simultaneously the British Medical Research Council and The National Committee of Radiation Protection (NCRP) reported similar recommendations. The Federal Radiation Council did not include medical radiation (estimated to be about half the recommended 10 R limit) and, thus, used 5 R as the 30-year limit for the population average in the Radiation Protection Guides. This is 0.17 R per year which is the value that continues to be in effect. There is at present no stated limitation on population exposure from medical practices.<sup>1</sup>

The BEAR Genetics Report (whose recommendations are used in the present Radiation Protection Guides for the general population) relied mainly on data from mice and *Drosophila*

(fruit fly) since very little human data was available. These creatures were exposed to high doses of radiation for as many as 40 generations. From the data thus obtained, the BEAR Committee estimated that the amount of radiation required to produce a mutation rate equal to that which occurs spontaneously (the "doubling dose") was approximately 40 R. Thus, the effect at equilibrium after a continuing exposure to the recommended 10 R limit per generation could be estimated.<sup>1</sup>

Continued research into possible genetic effects from radiation in animals and man now fill many volumes of the literature. These studies do not show genetic effects as prevalent as previously thought. "Animal studies carried out over many generations, with exposures of 200 rem per generation, show no apparent change in fertility or evidence of poor health. Furthermore, studies of the descendants of Japanese survivors of the atomic bombings show no evidence of genetic effects from the radiation exposure."<sup>2 3</sup> These animal and human studies suggest that the early genetic risk assessments were, if anything, overly conservative. These studies showed substantially fewer harmful effects than might have been expected from mutation rates for single genes.

The animals were exposed to high doses of radiation for many generations (more than 40) and yet the offspring showed no demonstrable effect on viability, fertility, or growth, nor were there any detected abnormalities attributable to the radiation.<sup>1</sup> Human chromosomes can now be studied with great precision, but, there is still limited knowledge concerning (1) radiation-induced mutation in man; and (2) the ability to quantify the relation between an increased mutation rate and deleterious effects on human well being.

Some fetal (teratogenic) effects were seen in some children born to pregnant and heavily irradiated mothers in the Japanese atom bomb survivors and these are sometimes misinterpreted by lay public as genetic effects.<sup>2 3</sup> The naturally occurring incidence of serious genetic disorders is about 107,000 per million births

and if one rem exposure were given to a population of parents it would be expected to produce an increase of only 5 to 75 additional disorders in the first generation. This same exposure to each succeeding generation would reach a genetic equilibrium of only 60 to 1100 disorders per million births,<sup>4</sup> a value within the uncertainty of natural effects.

## ***Somatic Effects***

In the early years following World War II, when little was known about the carcinogenic risks of radiation, genetic effects were considered the more serious. The situation is now reversed. We now know that the cancer risks are greater and the genetic risks less than previously thought.<sup>2</sup> Evidence available at this time indicates that the most important effect of radiation on the mortality of human populations is carcinogenesis, including leukemogenesis.<sup>1 5</sup>

Studies with differing types of external penetrating radiation administered to various species of animals reveal a dose-dependent increase in the incidence of neoplasms (chiefly leukemia) and a decrease in life span, down to as low as 10 rads. Results at this low dose are still fragmentary and will require far larger numbers of animals for verification.<sup>6 7</sup>

In regard to induction of cancer by ionizing radiation, the following observations are pertinent:

(1) The cancers induced by radiation are undistinguishable individually from those occurring naturally, and hence their existence can be inferred only in terms of an excess above the natural incidence;

(2) the natural incidence of cancer varies over several orders of magnitude, depending on the type and site of the neoplastic growth, the age and sex of the patient, and other factors;

(3) cancer of any one type occurs with sufficiently low incidence in man that few irradiated populations are large enough to provide statistically significant data on the incidence of tumors of any one type or site;

(4) the time elapsing between irradiation and the appearance of a clinically detectable neoplasm (latency period) is characteristically long; i.e., years or even decades;

(5) this long latency period complicates the prospective followup of irradiated populations for observation of possible tumor development, and it also complicates the retrospective evaluation of cancer patients for possible history of

relevant radiation exposure;

(6) in several instances, data have been derived from studies of therapeutically irradiated patients, in whom the effects of radiation may have been complicated by effects of the underlying disease itself or of treatments other than radiation;

(7) some of the data concern mortality whereas others concern disease incidence; in the case of cancer it is relevant to differentiate those radiation induced malignancies that do not greatly alter the death rate (e.g., thyroid carcinoma) from others that in the present state of knowledge are generally fatal (e.g., leukemia).<sup>1</sup>

A clear-cut increase in incidence with increasing radiation dose has been documented for several types of cancer in human populations, as well as for many types of neoplasms in experimental animals. Although, with few exceptions, the observed dose-incidence data pertain to relatively high doses (above 50 rem) and high dose rates (above one rem per minute), the findings for any given neoplasm are reasonably consistent from one irradiated human population to another. Estimates of the risks of effects at low dose levels involves extrapolation from observations at these higher dose levels, based on assumptions about the nature of the dose-response relationship, the mechanisms involved, the susceptibility of the population at risk, and other factors.<sup>1 8</sup>

To estimate the risk of cancer attributable to a particular increase in the level of exposure of the general population to ionizing radiation would require simply unavailable systematic information on the effect of life-long, low-dose irradiation. However an approximate calculation at the level of mortality can be made on the basis of the 25 and 35 year followup studies on atom bomb survivors and on patients treated with intensive spinal irradiation for ankylosing spondylitis. In the Japanese atom bomb survivors, the excess mortality from all forms of cancer, including leukemia, corresponds to roughly 50 to 78 deaths per million exposed persons per rem over the 20 year period from 1950 to 1970. In the spondylitics, the excess mortality corresponds to a cumulative total of roughly 92-165 deaths from cancer per million persons per rem during the first 27 years after irradiation.<sup>6</sup>

Based on the reviews of the National Academy of Sciences and the United Nations,



the risk estimate for cancer is about 100 cases per million person-rem. In other words, if a million persons are exposed to one rem above natural background during their lifetime, then the expected number of cancers in this group would be increased above the normally expected 200,000 cancer deaths by about 100 (i.e., from 200,000 to 200,100). Such a small increase, should it occur, could not be detected by statistical means, given the normal variability in cancer frequency.<sup>7</sup>

Applying risk estimates to the 60,000 people in the U.S. involved with radiation work and the approximately 200,000 people working with medical X-ray equipment who receive exposures of about 0.6 rem per year and 0.3 rem per year respectively, one can calculate that the risk of cancer above the natural cancer risk from these exposures would increase by less than 3%. Since the frequency of cancer varies as much as 10% among areas of the U.S., the risk of occupational radiation exposure even over a lifetime, is small compared with other environmental causes of cancer.<sup>2</sup> Risk to the general population due to these occupations would be even less.

The human organism appears to be most fragile at the extremes of life. Whether it is air pollution, starvation, or infectious disease, the elderly and the very young (particularly the in utero fetus) are at greatest risk. The effects of radiation are no exception to this pattern. Of the women who were pregnant and heavily irradiated at the time of the bombings, many bore children who were mentally defective and/or had microcephaly. Generally, the central nervous system seems to be the developing system most sensitive to radiation. Studies in both England and the United States have produced evidence of an increase in cancer among children exposed in utero.<sup>2</sup>

## Risk in Perspective

Obviously no risk, no matter how small, should be accepted if it is indeed readily avoidable. Traditionally, society has treated low and negligible risks as acts of God and has focused attention on the high risk category even though in this high risk range we find such voluntary activities as auto travel, plane travel, hunting, skiing, smoking and farther down the scale varying levels of radiation; public response will probably never be completely logical.

A painfully small effort is expended in reducing the loss of 250,000 lives a year (about 75,000 per year from lung cancer) as a direct result of smoking, yet, public abhorrence of specific catastrophes of very low risk, such as nuclear reactor melt downs, may result in large investments to avoid them, regardless of the quantitative importance.<sup>2,4,6</sup>

## Summary

Mankind has always lived with low levels of ionizing radiation from natural sources. An approximate estimate of overall cancer mortality can be made on the basis of followup studies on Japanese atomic bomb survivors and patients treated with radiation for diseases other than cancer. The internationally accepted estimates of risks suggest that the numbers of cancers and genetic defects induced in the general population by natural background radiation are not more than about 1 per cent of the numbers of cancers and genetic defects normally present in the general population. The added risks to the general public due to any present or prospective nuclear programs are minute compared to those from naturally occurring background and medical/dental radiation.<sup>1,9</sup> ●

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## Rocky Flats Hazards Weighed

In further discussion aimed at clarifying the Rocky Flats installation and its potential as a health hazard, *Colorado Medicine* here presents a partial transcript of a recent radio interview.

Dr. David Miller of the Clear Creek Valley Medical Society recently conducted this interview on KLAQ and KPPL jointly with Dr. Carl Johnson, Director of the Jefferson County Health Department, a very vocal critic of Rocky Flats, and member of the CMS Council on Public Health and Dr. Carlton Dean, a member of the Governor-appointed Rocky Flats Monitoring Committee as well as of the CMS Environment Committee.

The following is an abbreviated transcription of the interview:

Dr. Miller: Let's open the bag of worms right away. Dr. Johnson let me address you first. Is there a threat to the health of the people who live anywhere near Rocky Flats, in your opinion?

Dr. Johnson: Yes, I believe there is a threat to persons who live near the plant, because of the fact that the plant does release plutonium and similar compounds. Plutonium and similar compounds are very potent carcinogens. The plant has released rather large amounts.

Dr. Miller: Excuse me, what is a carcinogen?

Dr. Johnson: A carcinogen is a chemical or source of radiation which can induce cancer after a period of years. So, getting back to my response, one, plutonium and related compounds are very potent carcinogens; two, the plant does release these compounds in rather impressive amounts; and thirdly, these compounds, including plutonium, have been found in tissues of persons in the area.

Dr. Miller: Are you implying that persons living near Rocky Flats are being exposed to unsafe levels of radiation?

Dr. Johnson: Yes.

Dr. Miller: Dr. Dean, does the Rocky Flats Monitoring Committee feel that persons living near Rocky Flats are being exposed to unsafe levels of radiation?

Dr. Dean: In the past there have certainly been unsafe levels that have contaminated the area, in and about Rocky Flats. There has been some controversy among figures, some divergent opinion.

Dr. Miller: What evidence do you feel there is to show that people are currently being exposed to unsafe levels of carcinogens from Rocky Flats, Dr. Johnson?

Dr. Johnson: In areas near the plant, a survey I have done using samples from surface dust, shows levels of 3000; 398 times fallout level.

Dr. Miller: How are people exposed to this in their bodies?

Dr. Johnson: In the areas near the plant, I think that chief hazards would be the possibility of inhaling plutonium from surface dust. They'd also have an exposure to exhaust plumes from the plant; routine exhaust and exhaust from fires. In areas further from the plant, I think the hazard would be from inhaling plutonium and similar substances over a period of years. These are very well filtered plumes, it should be stressed.

Dr. Miller: What is the EPA's regulation for maximum radiation exposure.

Dr. Johnson: Four thousandths of a rem or four millirems.

Dr. Miller: Do you think some people think that the EPA is being unrealistic or over-conservative in setting that dose?

Dr. Johnson: No, I don't think that that particular regulation has been challenged. It is currently law. The viewpoint of the EPA is that such dosages add up from all sources.

Dr. Dean: The permissible dose, over the years, has become progressively less, therefore, I think you have to assume that there is always a potential danger from low-level radiation. Unfortunately nobody knows how much danger there is from low level radiation, and it probably will not be known for many years.

Dr. Johnson: One very important point in examining low level radiation is the different sources of radiation. For example one source is the almost instantaneous exposure from a chest x-ray which is over in an instant, gone, except for a few ions left in the body. The other source would be a small particle of plutonium which is stored in the bone. It remains there for many, many years. In fact, it requires 200 years to excrete half of the plutonium stored in the bone.

Dr. Miller: Plutonium has a long half-life, then?

Dr. Johnson: It's more or less a permanent resident in the body.

Dr. Dean: For 20,000 years.

Dr. Miller: So we can't get rid of it too quickly.

The understatement of Dr. Miller's closing remark indicates the sobriety so characteristic of the serious attitudes which doctors involved in this controversy bring to its consideration.





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Send nominations to the Confidential Awards Committee, 1601 E. 19th Ave., Denver 80218. These awards will be presented during the Colorado Medical Society's Annual Session, September 24-27, 1980, at The Broadmoor.



## CHIROPRACTICS ADDED TO BENEFITS IN GROUP PLANS

On April 22, 1980, Colorado Blue Cross/Blue Shield was permitted by State Insurance Commissioner J. Richard Barnes to add chiropractic services to their list of insurable group benefits. Blue Cross/Blue Shield had asked that x-rays of the spine, office visits for "medical emergencies," office visits with manipulation, and physical therapy modalities and procedures be reimbursable. There was an inquiry from the office of the Commissioner as to whether such benefits would cause a reduction of visits to physicians.

## ADULT FOSTER CARE STORY ADDENDUM (meaning that the editor left something out)

In the April issue of COLORADO MEDICINE, two factors need to be corrected and clarified:

Our report stated that the Colorado State Department of Health has announced development of a new program of adult foster care. The story was in error. Facts of the matter are as follows: The Colorado Department of Social Services, through its COUNTY offices, is providing ongoing counseling and assistance to Adult Foster Care Caseworkers in an effort to provide an alternative to institutionalization and isolation for adults who can benefit from such care. OF PARTICULAR INTEREST TO PHYSICIANS, if you are aware of adult individuals who would benefit from such foster care, please call the Adult Foster Care Caseworker in the following counties where the program is now in operation:

ADAMS	KIT CARSON
BENT	LA PLATA
BOULDER	LARIMER
DENVER	MESA (soon to be in operation)
EL PASO	MORGAN
JEFFERSON	PROWERS
KIOWA	PUEBLO
	WELD

Editor's Note: Our thanks to the Adult Foster Care Caseworkers who are performing in this most helpful role, and our particular thanks to Laurie Knight of the Adams County Department of Social Services who brought the program to our attention, and whose county was then excluded from the article, inadvertently.

## "OLD DOC EXPERIENCE" REMEMBERED IN NEW SOCIETY AWARDS PROGRAM

The Colorado Medical Society has inaugurated an annual media awards program to recognize excellence in medical and health care reporting in the newspapers/periodicals, television and radio news reports. This program, titled the Colorado Medical Society First Annual Robert L. Perkin Media Awards Program, is offering awards in news writing and reporting competition, in all of the newspaper, periodical, television and radio news outlets in Colorado. The awards program has been established in memory of ROBERT L. PERKIN, long-time editorial writer and columnist for the Rocky Mountain News, and for many years editor and writer for the Colorado Medical Society. Bob Perkin was best known in Colorado newspapers for his writing the syndicated column, "Old Doc Experience," which appeared in most Colorado dailies and weeklies outside the metropolitan area, from 1946 until his death in 1978. Bob Perkin was also noted for his book, "The First Hundred Years," in which Colorado, as a territory and then as a state, is factually portrayed. Bob Perkin, himself, received many honors and awards over the years for his excellence in journalism, historical writing and services to mankind, in general.

The Colorado Medical Society Committee on Public Information established the awards program, which commenced, in order that the quality of medical and health care reporting be improved and that the quantity of such reporting be increased. Criteria for the competition will stress the quality of reporting in conveying the meaning and impact of medical news to the everyday reader, listener and viewer.

Entries are restricted to the working press in newspaper and periodical publishing, radio and television broadcasting within the state of Colorado. Deadline for entries in the 1979-1980 awards program will be a postmark of no later than July 15, 1980. Materials must have been published or broadcast in Colorado, first, and between July 1, 1979, and June 30, 1980.

Winners in the various competitions will be announced and presented at an awards ceremony during the Colorado Medical Society's Annual Session at the Broadmoor Hotel in September, 1980.



# CONTINUING MEDICAL EDUCATION CALENDAR

PUBLISHED JOINTLY BY THE COLORADO FOUNDATION FOR MEDICAL CARE, COLORADO MEDICAL SOCIETY AND THE COLORADO ACADEMY OF FAMILY PHYSICIANS • 1601 EAST NINETEENTH AVENUE, DENVER, COLORADO 80218

## MAY 1980

### 3rd

**AMBULATORY MEDICINE: CURRENT TREATMENT OF COMMON OFFICE PROBLEMS.** Kaiser-Permanente, Lakewood Medical Office, 8383 W. Alameda, Lakewood, CO. Contact: James Adams, M.D., 232-1885. (5½ hours of AMA Category 1 credit).

### 7th

**ANTICOAGULANTS - WHAT YOU SHOULD KNOW.** Estes Park. Contact: Martin J. Rubinowitz, M.D., The Denver Clinic, 701 E. Colfax Ave., Denver, CO 80203. (2 hours of AMA Category 1 credit; 2 prescribed hours of AAFP credit).

### 9th-10th

**AMERICAN COLLEGE OF SURGEONS ANNUAL MEETING.** The Broadmoor, Colorado Springs. Contact: Vi Brown, Colorado Medical Society, 1601 E. 19th St., Denver 80218. 861-1221, ext. 241.

### 28th

**COLORADO REGIONAL NEURORADIOLOGY & COMPUTERIZED TOMOGRAPHY MEETING.** University Hospital, Denver. Contact: Leatha Kibel, Department of Radiology, University Hospital, 4200 E. 9th Ave., Denver, CO 80262. 394-7773. (3 hours of AMA Category 1 credit).

### 31st

**COLORADO CHAPTER OF THE ACADEMY OF PEDIATRICS ANNUAL MEETING.** Four Seasons, Colorado Springs. Contact: Vi Brown, Colorado Medical Society, 1601 E. 19th St., Denver 80218. 861-1221, ext. 241.

### 30th-June 1

**COLORADO OTOLARYNGOLOGY & MAXILLOFACIAL AND NEW MEXICO EAR, NOSE & THROAT SOCIETY ANNUAL MEETING.** The Broadmoor, Colorado Springs. Contact: Vi Brown, Colorado Medical Society, 1601 E. 19th St., Denver 80218. 861-1221, ext. 241.

**COLORADO RADIOLOGIC SOCIETY ANNUAL MEETING.** The Broadmoor. Contact: Vi Brown, Colorado Medical Society, 1601 E. 19th St., Denver 80218. 861-1221, ext. 241.

## JUNE 1980

### 7th

**DOWN'S SYNDROME WORKSHOP & DINNER.** Denver. Contact: Colorado Child & Adolescent Society, 1601 E. 19th Ave., Denver, CO 80218. 861-1221, ext. 241.

### 9th-14th

**26th ANNUAL FAMILY PRACTICE REVIEW.** Estes Park, Colorado. Contact: Office of Postgraduate Medical Education, University of Colorado Health Sciences Center, 4200 E. 9th Ave., Denver, CO 80262. 394-5241.

### 13th

**HEMATOLOGY/ONCOLOGY.** Denver. Contact: Office of Postgraduate Medical Education, University of Colorado Health Sciences Center, 4200 E. 9th Ave., Denver, CO 80262. 394-5241.

### 19th

**COMMON RASHES.** Vail. Contact: Martin J. Rubinowitz, M.D., The Denver Clinic, 701 E. Colfax Ave., Denver, CO 80203. (2 hours of AMA Category 1 credit; 2 prescribed hours of AAFP credit).

### 22nd-26th

**3RD INTERNATIONAL SYMPOSIUM: CANCER THERAPY BY HYPERTHERMIA, DRUGS & RADIATION.** Colorado State University, Fort Collins. Contact: W. C. Dewey, Ph.D., Department of Radiology & Radiation Biology, Colorado State University, Fort Collins, CO 80523. (303) 491-5096.

### 25th

**COLORADO REGIONAL NEURORADIOLOGY & COMPUTERIZED TOMOGRAPHY MEETING.** University Hospital, Denver. Contact: Leatha Kibel, Department of Radiology, University Hospital, 4200 E. 9th Ave., Denver, CO 80262. 394-7773. (3 hours of AMA Category 1 credit).

### 28th-30th

**PRACTICAL NEUROLOGY FOR THE INTERNIST AND FAMILY PHYSICIAN.** Aspen. Contact: Office of Postgraduate Medical Education, University of Colorado Health Sciences Center, 4200 E. 9th Ave., Denver, CO 80262. 394-5241. (16 hours AMA Category 1 credit).

### 30th-July 3rd

**CACMLE POSTGRADUATE CONFERENCE IN CLINICAL LABORATORY PRACTICE.** Hilton Harvest House, Boulder. Contact: Elmer W. Koneman, M.D., Colorado Association for Continuing Medical Laboratory Education, Inc. (CACMLE), 1601 Milwaukee St., Denver, CO 80206. (303) 321-1734.

## JULY 1980

### 2nd-5th

**ASPEN SYMPOSIUM ON AGING.** Continental Inn, Aspen. Contact: Aspen Symposium on Aging, Department of Communications Disorders, Area of Audiology, University of Northern Colorado, Greeley, CO 80639. 351-2012 (AMA Category 1 Physician Award Credit).

### 7th-10th

**OPHTHALMOLOGY: "PROBLEMS IN PEDIATRIC OPHTHALMOLOGY".** Vail. Contact: Office of Postgraduate Medical Education, University of Colorado Health Sciences Center, 4200 E. 9th Ave., Denver, CO 80262. 394-5241. (16 hours AMA Category 1 credit).

### **7th-11th**

**16TH ANNUAL POSTGRADUATE COURSE IN INTERNAL MEDICINE.** Estes Park, Colorado. Contact: Office of Postgraduate Medical Education, University of Colorado Health Sciences Center, 4200 E. 9th Ave., Denver, CO 80262. 394-5241.

### **13th-15th**

**HOSPITAL MEDICAL STAFF CONFERENCE AND HOSPITAL TRUSTEE FORUM ADVANCED SEMINAR.** Denver. Contact: Estes Park Institute, P.O. Box 400, Englewood, CO 80151. 761-7709.

### **16th-20th**

**SUMMER SKIN SEMINAR.** Aspen. Contact: Office of Postgraduate Medical Education, University of Colorado Health Sciences Center, 4200 E. 9th Ave., Denver, CO 80262. 394-5241.

### **18th-20th**

**CURRENT TOPICS IN ANESTHESIOLOGY: PHARMACOLOGY FOR THE YOUNG & OLD.** Keystone. Contact: Office of Postgraduate Medical Education, University of Colorado Health Sciences Center, 4200 E. 9th Ave., Denver, CO 80262. 394-5241.

### **21st-24th**

**PRACTICAL GASTROENTEROLOGY FOR THE PRACTICING PHYSICIAN.** Aspen. Contact: Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 E. 9th Ave., C-295, Denver 80262. 394-5241. (15 hours of AMA Category 1 credit).

### **21st-25th**

**INTERNATIONAL SYMPOSIUM ON HAND SURGERY — COMPREHENSIVE CARE OF THE DISEASED AND INJURED UPPER EXTREMITY.** Keystone. Contact: John A. Boswick, Jr., M.D., Course Director, 4200 E. 9th Ave., Box C-309, Denver 80262. 394-8718. (22 hours of AMA Category 1 credit).

### **23rd**

**COLORADO REGIONAL NEURORADIOLOGY AND COMPUTERIZED TOMOGRAPHY MEETING.** Department of Radiology, University Hospital, Denver. Contact: Leatha Kibel, 394-7773. (3 hours of AMA Category 1 credit).

### **31st-August 3rd**

**PEDIATRICS.** Snowmass. Contact: Office of Postgraduate Medical Education, University of Colorado Health Sciences Center, 4200 E. 9th Ave., Denver, CO 80262. 394-5241.

## **AUGUST 1980**

### **1st-3rd**

**COLORADO ACADEMY OF FAMILY PRACTICE ANNUAL MEETING.** The Lodge, Vail. Contact: Shirlee Meyers, 1570 Humbolt St., Denver. 837-0757. (11 prescribed hours of AMA Category 1 credit).

### **2nd-6th**

**PATHOLOGY IN OBSTETRICS AND GYNECOLOGY.** Aspen. Contact: Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 E. 9th Ave., C-295, Denver 80262. 394-5241. (28 hours of AMA Category 1 credit).

### **3rd-7th**

**PERINATAL MEDICINE.** Snowmass. Contact: Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 E. 9th Ave., C-295, Denver 80262. 394-5241. (21 hours Category 1 credit).

### **6th-10th**

**DYNAMIC PSYCHOTHERAPY: THE CONCEPT OF COUNTERTRANSFERENCE AND ITS RELATIONSHIP TO PSYCHOTHERAPEUTIC PROCESS.** Aspen. Contact: Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 E. 9th Ave., C-295, Denver 80262. 394-5241. (17 hours of AMA Category 1 credit).

### **11th-15th**

**ASPEN CONFERENCE ON PEDIATRIC DISEASE, 1980-LUNG.** The Gant, Aspen. Contact: J. Thomas Stocker, M.D., Department of Pathology, Children's Hospital, 1056 E. 19th Ave., Denver, CO 80218. 861-6712. (25 hours of AMA Category 1 credit).

### **15th-20th**

**PRIMARY CARE ORTHOPEDICS.** Aspen. Contact: Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 E. 9th Ave., C-295, Denver 80262. 394-5241. (23 hours of AMA Category 1 credit).

### **20th**

**WORKUP OF SUSPECTED AND PROVEN MALIGNANT DISEASES.** Aspen. Contact: Martin J. Rubinowitz, M.D., The Denver Clinic, 701 E. Colfax Ave., Denver 80203. (2 hours of AMA Category 1 credit; 2 prescribed hours of AAFP credit).

### **21st**

**ANTICOAGULANTS - WHAT YOU SHOULD KNOW.** Vail. Contact: Martin J. Rubinowitz, M.D., The Denver Clinic, 701 E. Colfax Ave., Denver 80203. (2 hours of AMA Category 1 credit; 2 prescribed hours of AAFP credit).

### **27th**

**COLORADO REGIONAL NEURORADIOLOGY AND COMPUTERIZED TOMOGRAPHY MEETING.** Department of Radiology, University Hospital, Denver. Contact: Leatha Kibel. 394-7773. (3 hours of AMA Category 1 credit).



# The ecology of primary ambulatory care:

## *Ramifications for the Future*

Susan Toshach Macfarlan, BSN, MPA, PNP, Boulder Colorado.

In the halls of health care and government one repeatedly hears that the overlap and duplication in health care is symptomatic of a poor delivery system, and that the overlap and duplication are heavy contributors to the high cost of medical care. I propose that the regulation of primary ambulatory care (PAC) would eliminate the overlap and duplication and, therefore, the diversity in PAC. The lack of diversity would actually exacerbate the existing problems of cost, quality and quantity of care.

It is assumed that the goal of primary ambulatory care is quality primary health care for all people. Quality care is partially predicated on quality relationships between health provider and client. It is also assumed that quality care is presently not available for all people. The present ecosystem of PAC includes three subsystems; private physicians, public institutions (health departments, emergency rooms, publicly funded neighborhood health centers, to name a few), and private, non-profit providers such as Planned Parenthood, Free Clinics, and "Rap" lines. (Table 1)

The subsystems are defined by their stated economic missions. That is, though most systems have incomes from two or three of the major sources, one source is dominant and/or is stated in the by-laws of the organization. Public institutions survive on public funding. Private for profit and private non-profit delivery systems may receive reimbursements from public Medicaid or Medicare and still remain private and autonomous.

What is the ecology of this PAC system? How did it evolve? Ecology will be discussed, PAC will be related to that system, and some questions will be asked.

An ecosystem is "formed by the interaction of a community of organisms and their environment."<sup>1</sup> Ecology is "the branch of sociology concerned with the *spacing* of people and institutions and the resulting *interdependency*."<sup>2</sup> (author's emphasis).

The interdependency of people and institutions implies stability. A healthy ecosystem is often defined as one that is stable. Stability for an ecosystem implies a lack of overdependence upon one system for the survival of the system or for the accomplishment of the goal. Stability arises from an interdependency of subsystems. Therefore, stability results at least partially from and promotes diversity within its subsystems.

Diversity allows a system to adapt to changes in the environment. Diversity is characterized by, and creates, stress. Stress results in competition, creativity, and flexibility. Competition, creativity, and flexibility in turn foster diversity (Fig. 1).

There are historical examples of the effects of diversity on an ecosystem. When left alone, nature often supply diversity. There will be a variety of trees in a forest; tall trees that like the sunlight will grow first providing shade for trees that are a bit sun shy. When diversity is reduced, the potential for an ecosystem failure increases. The story of 19th Century Ireland is well known. The potato became the primary crop. When it was blighted, the agriculture was wiped out and, subsequently, a large segment of the human and animal population died. The paucity of diversity in the Irish agricultural ecosystem reflected the lack of diversity in the entire political, economic, and social ecosystem; an ecosystem largely controlled by foreign interests . . . England.

How did the present system of PAC evolve? The subsystem of private physician care for pro-

Ms. Macfarlan developed the pediatric program, People's Clinic, Boulder, and also works with Eddy, Vtnall, and Hickman in their family Practice.

TABLE 1  
EXAMPLES OF HEALTH PROGRAMS BY  
THEIR PRIMARY ECONOMIC PHILOSOPHY

Private	Private Non-Profit	Public
Fee for service	Planned Parenthood	Water/sanitation
Solo practice	Free clinics	Well child clinics
Group practice	Abortion clinics	Child abuse/protection
	Robert Woods Johnson	VD clinics
MDs with a flat fee	funding of particu-	Grants for education
for a year's service	lar PAC	of nurse practi-
		tioners/PA
Private panel practice	Church health education	Environmental Protection
Private HMO	classes	Agency
		HEW's realm of health
Kaiser groups		
Smokenders Clinics		

fit has existed for centuries. In the United States the ecosystem was undiversified and did not deal with the health needs of a diverse and changing population. It did not accommodate the various political, economic and social/life-style needs, the diverse ages, geographic distribution, and perceived health needs of the people. The private providers did not, or could not, provide and regulate mass immunizations, sanitation inspection, and large scale preventive education.

Health Departments were formed to fill the gaps. Many have run well baby clinics, immunization programs, maintained surveillance of water sources and waste systems. Some have provided PAC. Frequently the functions are partially dictated by state law.

Still gaps remained. For example the private and public facilities could not, or did not, always respond to the public's need and demand for inexpensive birth control services, basic primary care for the working poor, or the increasing interest in self care and wholistic care. Usually it has been private, non-profit providers who first responded to these needs. Subsequently public and private sectors were catalyzed to action.

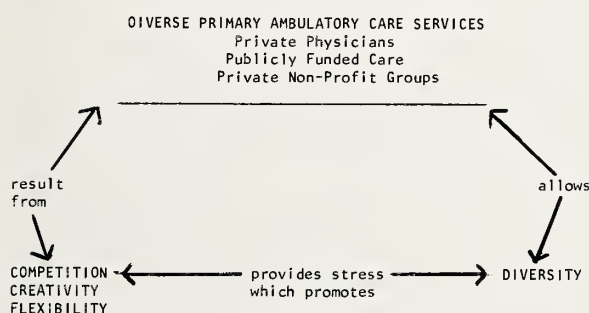
There is both stress and inter-dependency among the three groups. No one group had accomplished what the three together have been able to do. The diversity in the delivery of PAC provides stability, and stability results from diversity. The economic, political and social stability of the PAC system exists because one sub-

system (say the government) does not co-opt or control the entire system. The analogy to Ireland and England is not accidental!

Although it is heresy, I believe that quality PAC arises from some duplication of services. Duplication provides stress which catalyzes competition and creativity, among health providers to maximize the use of limited resources and to look at new ways for solving new and old problems. This competition results from the economic need for each subsystem to evaluate the needs and desires of the patient population and to influence or capture segments of that population. Two examples are worth mentioning. First, for a variety of personal and patient oriented reasons individual private physicians have formed group practices. Some are small fee-for-service groups. Others, like Kaiser, market comprehensive health services. The public equivalents of group practices are found in public hospital clinics and the Public Health Service facilities. Recently the federal government has encouraged maximizing economic and manpower resources by subsidizing Health Maintenance Organizations (HMO) and private physician panel practices. Private HMOs, Kaiser, the private panel practices and the private groups are competing for similar or overlapping populations; populations with private insurance or insurance through their place of employment or Medicaid or Medicare. Competition among the groups provides the majority of the public with some options, and may help control the cost of primary care.



Second, the private, non-profit groups provide a second example that competition also and creativity foster diversity and improved PAC through overlap and duplication of services. Venereal disease clinics in some county Health Departments were run only during a few day-time hours. Some Free Clinics saw the need for extended evening hours in order to reach more of the people in need of services, and instituted clinics which both overlapped and extended the Health Department program. Thus, the needs of the diverse population were met, the free clinics are cheaper to operate than health departments (by nature of their organizations), and the Health Departments ultimately extended their own VD clinic hours. The Free Clinic is then able to focus its resources upon other unmet needs.



If all care is legislated and funded from one source the voices and needs of patients and providers will probably not be heard. For example, the concerns of HEW seem to be in secondary and tertiary care. Yet the majority of the needs of most of the people are for primary care, including dental, eye, mental and general preventive care and education. Lowell Lewin indicated that one per cent of health funds are spent on preventive care, yet sixty per cent of the population is well. Seventy per cent of health funds are spent on hospitalized patients who number eleven per cent of the population.<sup>3</sup> Currently the Public Health departments are very concerned with increasing the percentage of children who are immunized against childhood illnesses. Nevertheless, in many geographic areas there is an equally great need for primary sick care for the children of the working poor.

On the other hand, certain primary care health education can be aided immensely by federal efforts to increase public awareness, as is occurring with the anti-smoking campaign.

Past experience indicated that when competition, creativity, and flexibility are not present within a geographic locality, it is a seller's market place and the buyer suffers. In health care such a situation is characterized by the following:

1. All care is delivered in the same fashion irrespective of the needs and life-style of the citizens.
2. All care is delivered at the same hours. Where do working adults and parents, who cannot take time off from work without loss of pay, take themselves or their children when they return from work or school with sore throat and fever?
3. Quality and quantity care for various population groups deteriorates. The elderly need inexpensive care, but are not comfortable in hip clinics. Working people need evening and Saturday clinics.
4. There is no incentive system to keep costs down and to work for wellness instead of sickness. Are there any rebates for *not* using health insurance?
5. A self-serving system may result.

It appears that the most successful ecosystem of primary care includes the checks and balances of a socialized health system, a private-for-profit system, and a private, non-profit system. What one does not do, the other catalyzes.

Without diversity there would be no stress, no competition, no creativity, and no flexibility to produce and market a variety of delivery modes of PAC to meet the needs of a diverse population. Economically feasible quality and quantity care would come to a standstill and then decline as a result of stagnation. It is probable that the most economically feasible way of providing primary ambulatory care is an extension and refinement of the present system of private, public, and private, non-profit PAC.

It will behoove us to examine why each economic group initiated its programs. What were the altruistic, the social, the economic, and the political forces at work? What can be done to encourage the health providers in the three economic arenas to continue to operate and expand in the spheres where they are most productive? The answers are probably available. The need is for synthesis and to make them operational. ●

<sup>1</sup> Random House Dictionary of the English Language, Unabridged, s.v. "Ecosystem".

<sup>2</sup> Ibid., s.v. "Ecology".

<sup>3</sup> Lewin, Lowell: Conference on Wholistic Health Care. San Francisco. Spring, 1977.

## CME and the Rural Doctor

Removed from the considerable resources of major hospitals, the rural physician has nevertheless to carry on a steady program of Continuing Medical Education.

Working through the Colorado Consortium for Continuing Medical Education, CMS in cooperation with the U.C. Health Sciences Center and the Colorado Foundation for Medical Care offers initial visits by medical education specialists who can help in the design of new programs and to improve existing ones.

Such questions as follow could be answered during a one-day session between the staff of a rural hospital and a consultant provided through the Colorado Medical Society and the Consortium:

- How do you start a CME program in a small rural hospital?
- If such a program is started, can we get Category 1 credits?
- Where can rural physicians obtain help and advice on a continuing basis?
- What is the cost of establishing a CME program?
- What topics should be covered in a CME program, and how is this best decided?

For further information about setting up a CME program, call: Kevin Bunnell, EdD, Director, Colorado Consortium for Continuing Medical Education, c/o Colorado Medical Society, 1601 East 19th Avenue, Denver 80218, or call: (303) 861-1221, x262 (Toll-free outside metropolitan Denver area 1-800-332-4150).

## Highlights of Accreditation Committee Meeting, April 3, 1980

The United Staffs of Boulder (Boulder Community Hospital and Boulder Memorial Hospital) received first time accreditation for 2 years by action of the CMS Accreditation Committee on April 3rd. Other actions of the Committee were: Colorado Allergy Society (reaccredited for 4 years). Penrose Hospital, Colorado Springs (reaccredited for 4 years); Veterans Administration Medical Center, Fort Lyon (reaccredited for 2 years); Rocky Mountain Hand Surgery Society (reaccredited for 2 years); Western Orthopedic Association, Rocky Mountain Chapter (reaccredited for 4 years).

The Committee reviewed the statewide picture of continuing medical education accreditation and

noted that more than 70 Colorado hospitals are not accredited for CME. However, only about 12 of these are both over 50 beds and eligible to apply for accreditation. The Committee recommended that consultation concerning the educational processes of CME be offered to those 12 hospitals.

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## obituaries

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Doctor **John McEwen Foster** of Denver died March 24, 1980 at the age of 80.

Doctor Foster was a native of Denver, born September 6, 1899, schooled in Colorado and at Salisbury Preparatory School, Connecticut, before entering the University of Colorado. He attended Harvard Medical School, receiving his MD in 1924. He interned at Presbyterian Hospital, New York City.

In 1928 he returned to Denver for a surgery practice, and later that year he joined Capitol Life Insurance Co., becoming assistant medical director in 1934, and director in 1940. He also maintained a private practice until retiring in 1961.

In 1942 he commanded personnel of the University of Colorado Medical Center at the U.S. Army's 29th General Hospital in New Caledonia where he passed 26 months. He also spent a year on Okinawa and Korea.

Doctor Foster belonged to the Denver Medical Society and the American Medical Association, as well as the American Surgical Association, American Association for Surgery of Trauma, the American College of Surgeons, the International Surgical Society, and the Denver Academy of Surgery.

His first wife, Margery M. Foster, to whom he was married in 1926, died in 1953. On February 22, 1964 he was married to the former Patricia Bissett, who survives.

Other survivors include two sons, Hugh Bethell and Brien Edward, both of Denver; two daughters, Mrs. Thomas Cosgriff II, Denver, and Mary-Jane Foster, New York City, and a stepson, John William McCall, Jr., of Denver.

Doctor **Gary L. Way** died in Aurora, Colorado on April 10, 1980 after a long illness.

Doctor Way was born September 9, 1945 in Cody, Wyoming, and attended schools in Sheridan before attending first the University of Wyoming and then the University of Colorado School of Medicine. He interned in pediatrics at Fitzsimons Army Medical Center, and received cardiology training at the University of Colorado Medical Center.

Doctor Way retired from the army in November 1979 as a major, and served in the cardiology department at Children's Hospital.

He was a member of the Colorado Medical Society, a fellow of the American Academy of Pediatrics, and a fellow of the American College of Cardiology.

He is survived by his wife, Patty F. Way, two daughters, Juli and Jami, and a son, Jeff, all of Aurora, and his parents, Mr. and Mrs. Robert W. Way, Sheridan, Wyoming.



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*Colorado Medicine* (ISSN-0199-7343) is published monthly for \$12 per year by the Colorado Medical Society, 1601 East 19th Avenue, Denver, Colorado, 80218. Second-class postage paid at Denver, Colorado. POSTMASTER: Send address changes to *Colorado Medicine*, 1601 East 19th Avenue, Denver, Colorado 80218.

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# president's letter

Thank God - it stopped snowing - I think! If any of you need to know where the worst curves are on I-70 or Highway 40, give me a ring.

There have been a myriad of interesting developments this past month. By the time you read this I am hopeful that we will have the required signatures to put the Helmet Law on the November ballot. At this time it looks great. Governor Dick Lamm was kind enough to put his name at the top of a petition for me, and is giving his full support to the matter. Lieutenant Governor Nancy Dick has also been most helpful.



Speaking of the Governor and Lieutenant Governor brings to mind a dilemma, among a number of problems during the year, in the funding of the Office of Rural Health. I have been watching this office daily, and truly believe they are making some real headway. The Colorado Rural Health Conference has attracted national attention, and Denver will be the site of a National Rural Health Conference in the spring of 1981. Rapid change in the rural health scene initiated by the energy boom experienced in one state has given impetus to great interest in many others. All this is in addition to the rapidly changing pattern of delivery of health services in rural areas throughout the United States.

Colorado's Office of Rural Health is in the process of doing an in-depth study of rural health personnel needs, and is making a serious attempt to match providers to consumers in these areas. Colorado Medical Society is cooperating in this study.

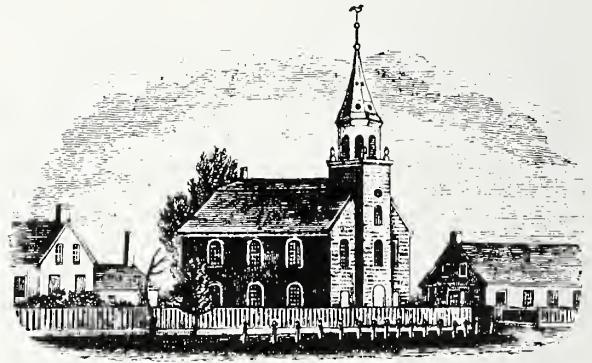
All this needs money. At the time of this writing, the money is not guaranteed. Federal loan agencies as well as private funding sources are being researched. Hopefully, necessary funds will be forthcoming.

It is my view that the initial personnel problems of our medical school are, for the most part, solved. Dean Schwarz will now have more time to turn his talents toward making our school one of the finest educational institutions in the world. The University of Colorado Health Sciences Center needs money to accomplish its goals. The public and the legislature need to make a crucial decision in the coming months and years: do we want to go first class as a medical institution and produce physicians second to none? Or, can we live with

mediocrity? I am convinced that this state has the economical resources, but do we have the real commitment and the dedication needed? Let us, you and me, go first class — be dedicated and committed to the end!

Next time you are in Denver, near 1601 E. 19th Avenue, drop in! We'd love to show you around. Things are happening! I believe we are climbing the ladder . . . slowly, but very surely!

*Ray S. W. Johnson*



## OUR COVER

*The Hypochondriac*

by August Lenox

Modern times did not bring about hypochondria. Man has always been so alert to his own feelings that the very tiniest suspicion of things going awry sent panic signaling throughout his system. Off to the nearest approximation of the apothecary, which might have been a tree or a bush, for the painkiller of choice he would go. August Lenox imagined the meeting of a country doctor with his most paranoid customer, and we thank him for the pleasure. For your own copy of the painting, send in the card at page      with your check for \$65.00.



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# guest editorial

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For several reasons, the physicians of the Denver area and, indeed, of Colorado in general, must be at pains to inform themselves on the subject of **holistic health**.

First of all, the basic premise on which this philosophy is founded is absolutely valid: that an individual, any individual, needs to assume responsibility for his own health. It is up to him (I refuse to stoop to saying him/her - you can do that yourself) to modify his diet, to regulate his daily exercise and to learn how to control both environmental and personal stresses so as to avoid adverse effects on his health.

It is obvious that this sort of program may involve advice and guidance, quite legitimately, from a variety of non-physician counselors. Who can say that a well-trained and sympathetic clergyman is not qualified to advise an individual on methods of dealing with stress? And, who can deny that a licensed nutritionist can advise an overweight patient with a serum cholesterol of 330 mg. % on the virtues of a diet of - say - Chinese food? And, who can say that a graduated exercise program devised by a physical therapist with experience as a trainer would not benefit most of us pot-bellied sybarites?

The problem is, of course, that there is a host of untrained, but shrewd, "experts" of all sorts who are willing to fill the need, which brings us to the second reason for us to be interested in holistic health.

The second reason is that our patients, especially the younger ones who grew up during the '60s and '70s, have looked to the medical profession for guidance and have failed to find it. Most of us know relatively little about dietary matters, and we often tend to refer such *infra dig* questions to our office assistants, who probably know more about the questions than we do, but do not carry the authority the patient is seeking (and has paid for). How comfortable do we feel about discussing stress avoidance and learning to be in harmony with the cosmos? This, in our stressful, threatening times, is what our patients need and want. Who can blame them for following some guru who promises them a light on their journey through the dark?

Most physicians, as has been repeatedly stated, are disease-oriented. To tell the truth, we thrive on the occasional exotica. The promotion of wellness, that is, not just the absence of illness but the achievement of optimal physical, mental and spiritual well-being, is just too boring for almost

anyone except maybe the pediatrician. If we fail to display an abiding interest in the true well-being of our patients, then we deserve to lose them to the often misguided, often self-seeking, often downright dishonest ministrants of faith-healing, spinal adjustment and brown rice diets. But, in truth, even though we may deserve such a fate, our patients do not. They deserve better, which brings us to our third point.

The third reason we need to inform ourselves about the concepts of holistic health is so that we, with our scientific training, may remain in charge, as it were, of the health care delivery team. We are, after all, the ones best qualified to determine the best care for a given patient. We need to know what it is these other "disciplines" are offering our patients and why our patients are so willing to give them a try.

It serves nothing to rave at "quacks," rather we must enter into the fray and prove, by our interest in the whole man and his well-being, that we are indeed concerned about health as contrasted to disease, and that we mean, with our superior tools, to turn our attention to this matter.

**Peter C. Hoch, MD, Chairman**

**DMS Task Force on Holistic Health**

**Denver Medical Society Bulletin**

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# new officers

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10	232,428	169,202	155,295
20	560,440	286,294	241,171
30	1,326,770	484,416	374,532



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## letters to the editor

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Mr. Bill Pierson  
COLORADO MEDICINE

Dear Mr. Pierson:

As you are well aware, there is a multi-pronged attack on the medical profession, its integrity and its credibility, being waged by agencies and persons of the federal government, including Senator Kennedy, the Federal Trade Commission, and HEW. In my opinion, naturally, the attack appears both unfair and the information misleading.

It seems to me that the medical profession is losing this battle by default. I know that in my own contacts, the majority of physicians I speak with are thoroughly dissatisfied with the attempts on the part of organizations of medicine to refute this attack.

To the best of my knowledge, the AMA and the Colorado Medical Society have chosen as their battlegrounds the courts and the legislature and have met with limited success in both areas. As near as I can tell, the AMA has one of the largest and most thoroughly unpopular lobbying organizations in Washington.

It is absolutely inconceivable to me that medicine should be as unpopular with the general public as it is today. We physicians deal with patients on a one to one basis. We sit them down in front of us, we talk to them and have a much more personal relationship than any politician could possible have.

We have an opportunity the politicians don't have and that is to present our side of the story in a favorable and personal manner to hundreds of thousands of patients who have ten times that number of friends and relatives. In addition, organized medicine has maintained a scandalous silence with regard to the public. As near as I can tell, the AMA and the Colorado Medical Society have done nothing to demonstrate to the public any concern for their well-being or their health. These are groups that could reach large numbers of people through the public media and do much to project a different image of medicine than is currently prevalent.

I don't believe I can remember ever seeing a preventive health or public health message on TV (or even hearing it on radio) that was presented by the AMA or the Colorado Medical Society. Instead, I have heard messages from the American Dental Society, the American Heart Association, the American Lung Association, and even the Roche Laboratories that demonstrated a greater concern for public health than either the AMA or the

Colorado Medical Society. Therefore, I believe the Colorado Medical Society and, indeed, the AMA, ought to adopt a three-pronged attack in its own defense.

I believe the first thrust should be to demonstrate the concern that I believe most physicians feel for the health of their patients. This should, in my own mind, consist of a large number of 30 to 60-second spots on both TV and radio and half or full-page ads in major newspapers advising the public, not so much to go see their doctors, but how to care for themselves. These messages could very quietly be followed by a statement to the effect that this message of concern for your health is presented to you by the Colorado Medical Society. The purpose of this campaign would be to project a different and more concerned image of medicine to the public.

The second prong of the attack, I believe, should be one that describes our side of the story. Believe it or not, there are few people out there who actually realize the effort, time and expense a physician puts into this training. They have no idea of the gross discrepancies between so many of the bills that the physician presents and what Medicaid actually pays. Patient after patient has told me that they thought Medicaid paid 100% of the bill. It ought to be pointed out to these people, in a diplomatic way, that the physician is taking care of them, hardly for the money that Medicaid pays him, but rather because they need to be taken care of. The public ought to realize the incredible amount of paperwork and the manhours required by government programs in medicine. They ought to be made aware of the additional expense, both to the patient directly and to the taxpayer, by the involvement of the government in medicine. They ought to be made aware of the ridiculous inconsistency in the recent attacks by the FTC on relative value manuals, while insurance companies, on the other hand, not only require them (RVS manuals), but publish their own. They ought to be made aware of the price of mal-practice insurance, the effect of lawyer's contingency fees, and though there has been information on this in the news media, it's usually colored in a light that makes the contingency fees, excessive as they are, a necessary evil.

Information such as this can be presented in ads taken out in major magazines such as Aetna Insurance Company is doing, and by printing pamphlets available for reading in physicians' offices all over the state.

The third prong of the attack has been alluded to already, but should be a direct public attack on existing government systems of medicine, such as the VA (which, if my information is correct, was recently told to bring their standards of care up to that of the private sector). It should be made quite plain to the general public there will be no free ride in national health insurance and that existing forms

of medical care run by the government in both this country and other countries, is, as a rule, less comfortable and less convenient than that provided by the private sector.

In short, I believe we should first attempt to change the image of organized medicine with the public and, secondly, present our side of the controversy in a public forum. Thirdly, we need to point out the inadequacies of government intervention in medicine, both as it exists today and as it is proposed for the future.

I am not a right-wing John Bircher, but I do feel that medicine is doing nothing to defend itself in the public forum, which will ultimately decide the course of medicine as we know it today. Instead, it appears to me that we are going around sticking our fingers in numerous holes in the dike, with our lobbying and often unsuccessful lawsuits.

I hope you will find this letter of some worth.

Very sincerely,  
Michael J. Shoo, MD  
Cortez, Colorado

## Letter from the Editor

TO: Michael J. Shoo, MD  
18 South Beech  
Cortez, Colorado

Dear Dr. Shoo:

Thank you for your letter. May I congratulate you for your depth of insight into the public problems of medicine today. That is an editorial comment. I can't agree with you more. Let me address your points, generally in the order that you presented them.

You are right in assessing the physician's position as one of being in battle with the federal government, various agencies and lawmakers, as well as the general public; however, there is a change in the making. Witness: my position was created within the Colorado Medical Society, for the first time in over one hundred years, just six months ago. Officers and trustees of Colorado Medical Society did realize that nothing very positive about the practice of medicine was emerging in the public information stream, nor was there a very positive image being maintained of the practicing physician. During these six months my office has, at least, started to address these areas of concern with the following:

- A series of weekly radio programs wherein the doctor tells the listener how to stay healthy without going to the doctor.
- A long-term campaign to sell "health-power" through the use of radio, television, newspaper and pamphlet, which is being distributed through physician's offices, clinics, personal billing, emergency rooms, group homes, etc., selling preventive medicine . . . for the good of the consumer.
- A series of weekly newspaper columns espousing preventive medicine, as prescribed by the physician, in the interest of the public.
- An extensive campaign for reinstatement of the Colorado motorcycle helmet law, to curb the serious increase in head injury and long-term brain damage, which was resulted from the repeal of the mandatory helmet law two years ago. This very active campaign for reinstatement is certainly not for the good of the physician, but for the good of the public.
- A continued lobbying effort at the state level, not to shape an opinion but to assure the legislator that he/she has the correct and accurate information concerning health care services in Colorado.
- A continued effort to provide a resource for accurate and complete information concerning the practice of medicine to those journalists and reporters who long have been ill informed (or not informed) of the physician's position. The Communications Department of the Colorado Medical Society is attempting to establish just such a full-time resource center for the news media, creating a worthwhile incentive for the reporter to publish the many stories concerning the medical aspects and health care of Colorado.
- Continued efforts to strengthen the communications *WITHIN* the physician community of Colorado, in an effort to overcome the seeming indifference of the physician to these issues.

I can't agree with you more when you say that we seem to be going around sticking our fingers in numerous holes in the dike, and to little avail. My approach to all those problems you mention is that the physician fraternity, also known as the Colorado Medical Society, should become PRO-ACTIVE rather than RE-ACTIVE! The Society must carefully assess what are the most meaningful issues of the day, address them in a conscientious manner, and then establish a position on these matters, publicly. It is difficult, I know, for a physician to maintain a practice, provide proper care for those patients, and still have time and energy to carry on all these projects to protect the private practice. However, if we can get that physician to communicate with the Colorado Medical Society through his or her component society, and if that physician, in turn, will read and respond to *COLORADO MEDICINE*, we



can place medicine and the practitioners in a PRO-ACTIVE attitude.

I don't believe it is necessary to discuss the various differences that private practice holds with federalized medical and health care. You are right in saying that the public needs to be better informed as to the effort, expense and personal hardship involved in becoming a physician. You are right in saying that much more could be done in the form of "paid" advertising of the physician's position on all of these and many other subjects. I, personally, do not believe an all-out paid advertising campaign is necessary. . . yet! The news and information media are still attempting to be objective in their approaches to these matters. The media, in general, are still willing to allow their space and time to be used to tell a true story in the good of the public. A type of paid advertising campaign may well be necessary soon, unless the medical community, particularly the physicians, can adapt to a proactive stance.

As you say, "in short," it is not as much a need to change the image of organized medicine as it is to stop the erosion of that image. We can do that by presenting the physician's side of the public, but not in the controversial forum; I don't believe that is necessary. And, too, we need to point out the weaknesses of government intervention in medicine, both as it exists today and as these interventions are proposed for the future.

All of what we say is true, to one degree or another; but all is not lost in today's Colorado

Medical Society. There are changes afoot, though they are small when compared to the picture you project. The measures I propose, I admit, are treatment for the chronic rather than the acute (critical) illness. We have to start somewhere, though, and to wait for a miracle cure of the acutely ill is not the answer. There actually is no such miracle cure. Paid advertising, for example, will have as many new, adverse effects as the patient (victim) already suffers in the primary infection. My prognosis is that it is not too late, but the treatment must be a 100%, "holistic" plan, if you will. The closest thing to a cure-all has to be in the participation of as large a majority of physicians in Colorado coming together in a single voice through the Colorado Medical Society. Your voice has certainly been heard in the Society. But don't rest on that. Let us, at the officer and the staff levels, hear more from you, and on all subjects of concern to your practice.

I have mentioned only a few of the many approaches we (CMS) are taking to better inform the public and the physician. In each of these measures or strategies the critical factor is the physician participation. Your early help is greatly appreciated.

Sincerely,  
Bill Pierson  
Executive Editor  
Director of Communications

## RESIDENTIAL SITES INVESTMENT OPPORTUNITIES STEAMBOAT SPRINGS WILLETT HEIGHTS SUBDIVISION

Incorporated in the city of Steamboat Springs. Above town, sunny, great views, paved roads and all utilities to lot lines, Single family lots and larger multi-family parcels available.

Peter Loram  
CDS - Steamboat, Ltd.  
(303) 879-5828

Obtain the property report required by federal law and read it before signing anything. No federal agency has judged the merits or value, if any, of this property.

**Preliminary Program  
of the  
110th Annual Session  
COLORADO MEDICAL SOCIETY**

**September 24-27, 1980**

**The Broadmoor**

**Colorado Springs**

*Decade of the Eighties*

**WEDNESDAY,  
SEPTEMBER 24**

*Morning*

House of Delegates

*Afternoon*

Reference Committees

Auxiliary Tennis Tournament

*Evening*

Reception

- Practice Management -  
(Luncheon Preceding Session)  
Long Term Financial Planning  
Time Value of Your \$  
The Blues and You - Insurance in the 80's  
The Plaintiff's Attorney: View of Your Case
- Auxiliary County President's Meeting  
Men's Tennis Tournament
- Evening*
- Reception and Dinner-Dance

**THURSDAY, SEPTEMBER 25**

*Morning*

- COMPAC Breakfast Meeting
- Legislative Keyman Training Session
- Auxiliary Board Meeting, General Meeting, and Luncheon
- Physician's Golf Tournament

**Scientific Program**

**Concurrent Workshops**

- Atherosclerosis  
Prevention of atherosclerosis  
Importance of Antithrombin III deficiency and hypercoagulable states  
Recognition of cerebral vascular disease
- Infections  
Obstetrical infections  
Prophylactic antibiotic usage and the high incidence of nosocomial infections, and how to prevent them  
Hepatitis

*Afternoon*

**Concurrent Educational Programs**

- Computers for Colorado's Physicians  
Presentation of computers and telecommunications systems that physicians can use in their practices

**FRIDAY, SEPTEMBER 26**

*Morning*

**Scientific Program**

- Concurrent Update Sessions  
Update on management of chronic obstructive pulmonary disease  
Update on peripheral vascular disease  
Update on joint replacement surgery  
\* \* \*
- Update on diabetes mellitus  
Update on thyroid disease  
Nutrition and management of the obese patient  
\* \* \*
- Allergy (management of status asthmaticus)  
Update on peptic ulcer management  
Drug use and the elderly  
\* \* \*
- Update on new antibiotics  
Update on Reyes Syndrome  
Update on pelvic inflammatory disease (PID)  
\* \* \*

**Lanning E. Likes Memorial  
Cancer Lecture**

Detection and Diagnosis of Lung Cancer

- Auxiliary - MD Workshop

*Afternoon*

- House of Delegates



## SPEAKER'S SOLILOQUY

In past years the House of Delegates has functioned more as a review body rather than a body to initiate action. Most of our time has been taken with review of reports from various councils and committees. This year I would like to see more action initiated by all component societies for deliberation and action by the House of Delegates — resolutions are the best way to accomplish this and may be submitted by any component society, Delegate, Administrative Council or Trustee. If you have action you want taken, why not submit a resolution at the next meeting through one of these individuals.

Please realize that the "Whereas" is only informational and present your reasons for the "Resolve". The "Resolve" portion of the resolution is the part that is adopted and must stand alone. If you have any questions about the format for a resolution, speak with me or Dr. Ted Sadler, Vice Speaker, or one of the CMS staff and we will be happy to assist you.

We review all resolutions before their introduction and may call you for clarification if we are not sure of your intent.

Richard F. Bedell  
Speaker of the House

Credit - Participants will earn up to 12 hours of AMA Category I credit by attending scientific programs.

Registration Fee - There is no charge for attending any scientific session with the exception of physicians who are non-members of CMS.

Scientific Exhibits - Space will be made available on Thursday, September 25, for scientific exhibits. Those interested should contact Virginia Bell at CMS, 1601 East 19th Avenue, Denver, 80218, or Call: (303) 861-1221, and a form will be sent to you.

**ROOM RESERVATIONS - MAKE YOUR ROOM RESERVATIONS FOR THE CMS ANNUAL SESSION DIRECTLY WITH THE BROADMOOR BEFORE THE MIDDLE OF AUGUST.**

### Deadline for Reports and Resolutions

Any resolution requiring additional finances and/or a change in the dues structure necessitating a vote of membership must be in the hands of the executive office 75 days prior to the meeting of the House of Delegates (July 11, 1980) and in the hands of the component societies 60 days prior to such meeting.

All reports of Officers, Boards, Councils and committees reporting to the House and all resolutions must be in the executive office 45 days before the Annual Session opens (August 8, 1980).



TV camera shooting over head of Jerome Lynch, Blue Cross/Blue Shield.

## 1980 LEGISLATIVE SEMINAR VAIL, COLORADO May 23, 24, 25

Some candid photos of the participants in the various seminar meetings are indicative of the high interest level. Excellent participation by both the guests and the panel members helped the audience stay involved in the programs.

The large meeting room at the Lodge at Vail allowed approximately 100 persons to be seated and involved in each of the four sessions which were held.

The good weather was tempting to many to break away from the seminar and play golf or tennis or just get out into the mountain air; however, the mountain air was still quite cool, so interest in the meetings remained high.

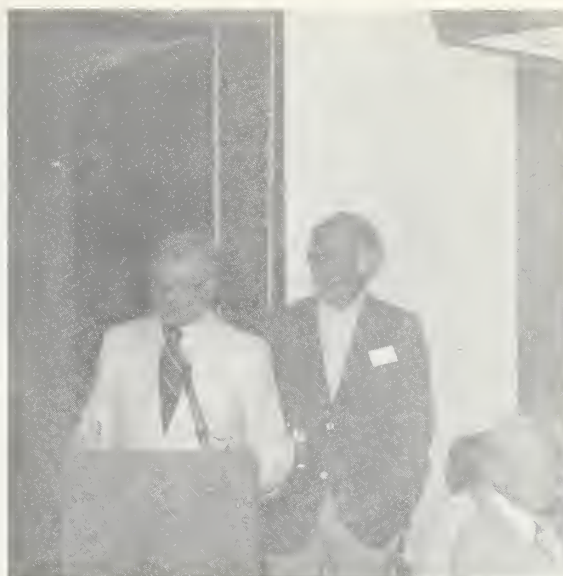


Members of Blue Ribbon Panel as they listened to and challenged the wrapup panelists Sunday morning.

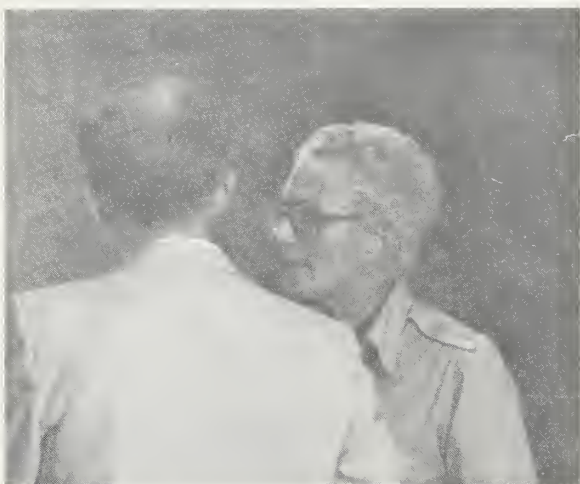




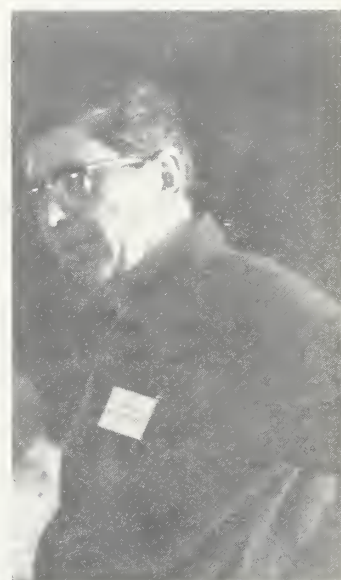
**Rep. Ron Strahle, Ft. Collins.**



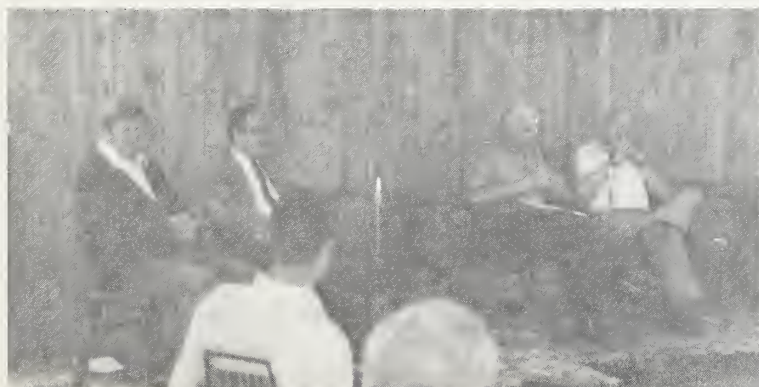
**Senator Hugh Fowler, Littleton, with Dr. Charles DaFoe in the evening entertainment supplied by legislators.**



**Sen. Sam Barnhill, Jefferson Co., challenging panelist. Moderator Bill Pierson with back to camera.**



**Sen. Harvey Phelps, MD, Pueblo.**



**(L to R) Joseph Butterfield, MD, Richard Weil, III, MD, Jerome Lynch, Rep. Carl Gustafson, in Sunday morning challenge round.**



**Rep. Carl Gustafson challenges panel.**



**Representatives Claire Traylor and Tom Tancredo headed legislative "chorus" in Saturday night variety program.**

**Sen. Wm. Hughes, Colo. Springs.**



**Joel Karlin, MD, Clear Creek Valley, addresses legislators.**



## 1980 PROPOSED STATE HEALTH PLAN

In late June the Colorado State Health Planning and Development Agency (SHPDA) will begin distribution of a proposed statewide health plan whose design is to improve the health status of the population and to achieve the necessary changes in the health systems in Colorado.

This proposed statewide health plan focuses on 14 specific health services and four areas of state health policy. Those services are:

1. Public Health
2. Primary care (personnel)
3. Emergency medical services
4. General acute hospital inpatient care (beds and capacity)
5. Critical care
6. Obstetrical/newborn
7. Inpatient pediatrics
8. Computerized tomography scanners
9. Radiation therapy
10. Cardiac catheterization and open heart surgery
11. Nursing home care
12. Home health care
13. End-stage renal disease services
14. Blood banking

Particular areas of state health policy to be addressed by the plan are:

1. The rising costs of health care
2. Health care financing for the medically indigent
3. Alternatives to institutionalization for the elderly
4. Health promotion and wellness

Interestingly enough, the health promotion section of the plan calls for a 10% decrease in the statewide consumption of cigarettes and for 80% of the state's population to be within 20% of their ideal body weight.

The Colorado State Health Department will, as earlier said, distribute this proposed plan in late June, and public hearings on the plan will commence about July 3rd in Pueblo, Grand Junction and Denver.

For further information concerning the proposed state health plan contact Barbara Yondorf, Colorado Department of Health,

## LATE REPORT ON HIGHLIGHTS OF COUNCIL ON PROFESSIONAL EDUCATION MEETING

The Council on Professional Education held a meeting on May 20, 1980, at which time the Council was advised that the Board of Trustees of the Colorado Medical Society approved the Council's recommendations that the Society stop notifying the Liaison Committee on Continuing Medical Education of the Society's accreditation actions, and that Colorado Medical Society should not oppose the Board of Medical Examiners if the Board should choose to recognize the LCCME credits for the purpose of relicensure.

The Council members voted to endorse the recommendation to the Board of Trustees that Colorado Medical Society rescind its approval that the American Medical Association release Colorado Medical Society's accreditation records to the new LCCME.

The Council discussed favorably the idea that the new COLORADO MEDICINE should include more material on clinical topics than it has in the past several months.

It was voted that the next meeting of the Council on Professional Education would be held on July 29, 1980, in order that the Council can submit resolutions to the House of Delegates prior to the deadline date of August 8th.

### LEGISLATIVE SEMINAR TERMED SUCCESSFUL ON ALL COUNTS

It was the year of the short session, and many of Colorado's legislators probably thought they were going to be involved in a lengthened short-session when they were invited to attend a legislative seminar at Vail, Colorado, on May 23-25. However, most were pleasantly surprised when the seminar turned into an informative (and fun) weekend for the physician and legislative participants.

In summary, the weekend was a different approach to discussing the continuing problems of medical and health care costs. It was different in the sense that the typical workshop was not used; instead, a series of panels which involved exchanges with the audience and challenges from the audience were cast in a public media atmosphere. Two of the panels took on the appearance of a television interview, audience-participation show, which allowed all participants high visibility, plus the opportunity to go back and review what their input had been. These two workshops, dealing with health care cost, were recorded on video tape and shown later. They will be the basis for assessing the value of the discussions as well as the value of such workshop-seminars.

The schedule called for the individual sessions to begin on Saturday morning at 8:45 with the keynote speech delivered by William M. Robinson, MD, of Denver, entitled "Are We Spending Too Much on Health Care?"

Immediately following this was the panel, "Are We Spending Enough on Health Care?" with Jerome Lynch, President of Colorado Blue Cross/Blue Shield, Robert S. Brittain, MD, Colorado Representative Steve Durham and Senator Ted Strickland. There were no conclusions (as expected) but there was a lively and worthwhile exchange of ideas and information.

The third session of the morning was "Who Shall Live?" with Moderator and Panelist L. Joseph Butterfield, MD, and Richard Weill, III, MD, Francis J. Major, MD, Colorado Representatives Carl Gustafson and Dorothy Witherspoon.



The Saturday luncheon speaker was Lorraine Lohman, Assistant Director of Cardiac Rehabilitation, St. Luke's/ Presbyterian Hospitals. The subject, "You Have The Duty to Stay Healthy." Ms. Lohman concentrated on the wellness aspects of lifestyles as well as preventive medicine.

Another panel on Saturday afternoon was placed in the television format, this time titled "We're Trying to Contain Costs --- Honestly." Participants were Mary Jean Berg, MD, Parker E. Preble, MD, Colorado Senator William J. Hughes and Representative Robert N. Shoemaker. The Saturday session ended about 30 minutes behind schedule and, even though many participants wanted to get to the golf course or tennis courts, no one left the session before it was ended. Interest remained high and attendance at all sessions was excellent, both for the physicians and legislators and for their spouses.

A dinner which included "music and healthy entertainment" was held Saturday evening. Only seven persons, total, were not present for the dinner. Following the meal the legislators and the physicians presented their own, original entertainment and talents. Legislators composed lyrics and performed them to the music of "H. M. S. Pinafore." Author of the lyrics for the lawmakers' chorus was Senator Hugh Fowler. When it was time for the physicians to rebutt, so to speak, Frank Traylor, MD, Director of the Colorado Department of Health, stepped forward. He had composed a physician's musical reply to the legislators, also to the music of "Pinafore." Both chorus performances, with the solo efforts of Senator Fowler and Dr. Traylor, were well received and paid high tribute by the audience.

On Sunday, May 25, a general session was held during which members of each of the previous day's panels summarized their feelings and positions on the subjects, and were then challenged by select members of a "blue-ribbon" committee. This exchange lasted for three hours without a letup. Most observers said they felt the exchange was honest and straight-forward, generally a healthy and worthwhile conversation which should aid in better relations between the physicians and the legislators in the future.

This seminar was, admittedly, different than previous such meetings, primarily in the way the various panels were conducted. However, it is generally agreed that the format aided in getting a freer-flowing dialogue going between the two sides and the other interested parties as well. Our next report will detail the comments and criticisms of the participants, based on their own individual evaluations.

#### LOOKING BACK ON 9 HEALTH FAIR OF 1980

The Colorado Medical Society Communications Department has received many requests for (1) results of the 9 Health Fair, (2) reactions to the 9 Health Fair, (3) plans for the 9 Health Fair in 1981, and (4) reasons why there were not more CMS member-physicians participating in the 1980 9 Health Fair. A summary report follows:

In late-1979 and early-1980 the 9 Health Fair blossomed on the Colorado scene with little advance notice of its having been already planted and cultivated. Plans for the 9 Health Fair, in fact, took many physicians and staff members of Colorado Medical Society quite by surprise. The surprise aspect was that the planning had progressed so far without the knowledge or involvement of Colorado physicians. This is not a negative comment; however, this fact does have a great deal to do with answering all of the four questions stated above.

Prime mover behind the 9 Health Fair was the National Health Screening Council for Volunteer Organizations, Incorporated, based in Washington, D. C., and headed by John Brensike, MD. Locally, KBTv-Combined Communications Corporation, agreed to sponsor the statewide community health screening. Executive Director of the 9 Health Fair was Annette Finesilver. Initial plans for the health screening included tests for blood pressure, hearing, glaucoma, sickle cell anemia, tuberculosis, gout and diabetes. In addition, there were podiatry exams, breast exams, pap smears, respiration therapy and a potential for other screenings, depending on community interest and support. Early plans for the 9 Health Fair were based on "The team approach to Health Fairs," which included the "site, non-medical volunteers, nursing volunteers, allied health volunteers and financial sponsors."

Following the earliest meeting between KBTv personnel and officers and staff members of Colorado Medical Society (in October, 1979) it was decided that any participation by CMS in the Health Fair would be a matter to be considered by the Board of Trustees before any further involvement were to be undertaken.

To shorten this report, it is sufficient to say that the Board did give the matter of participation in the 9 Health Fair lengthy and repeated consideration, and decided that the Colorado Medical Society would not directly involve itself, but would offer its assistance by cooperating with the health fair organizers, would publicize the 9 Health Fair through its own communications, would advise where it was deemed helpful, and would make the 9 Health Fair known to all staff, in order that they might do some volunteer work for the health fair. The Board did not, however, condone the number and type of "screenings" to be offered at the variety of screening sites. Physicians were concerned about the ability to perform a medically-effective program, since some of the screening efforts were more on the order of examination components. Physicians from a number of the component societies in the Denver area were also concerned about possible liabilities which might result from such screening tests; they, therefore, chose not to enter into direct participation or sponsorship of the 9 Health Fair.

Physicians of the Metro Medical Council of Presidents also voted to accept screening results only from individuals rather than from 9 Health Fair personnel who were responsible for follow-up to the screening. National Health Screening Council had proposed that results of a screening which were abnormal, and in which the



individual had not been examined by a physician for a certain period of time, be sent directly to a physician. The Metro Medical Council of Presidents urged that the results of such screenings be returned to the individual, who should then contact a physician of his/her choice.

The Denver Medical Society Board of Trustees also voted not to be directly involved with the 9 Health Fair, for substantially the same reasons. DMS made the 9 Health Fair plans known to their own membership for the purposes of soliciting volunteers to participate in the program.

Efforts were made to involve physicians, voluntarily, in the follow-up screening process known as the Health Hazards Assessment. It was decided, however, that physicians were not needed at this point, since the assessment involved not so much the medical evaluation of health hazards as it involved the reporting of an evaluation made by a computer at the National Disease Control Center and returned to the participant. Therefore, volunteers from the medical and health education field were recruited for the follow-up reporting.

It has been generally decided that if the Colorado Medical Society is to take a more active participation in a 1981 9 Health Fair, planning for such an event should commence on a state-wide level in late summer, 1980.

KBTB, Channel 9, has reported to CMS that between 51,000 and 52,000 persons went through the week-long screening. No final tabulation of results of the screening are available at this time; however, from all reports the screening was considered highly successful. Colorado Medical Society has already arranged a meeting with Annette Finesilver and her staff in mid-June to assess the results and commence dialogue toward the next Health Fair. It is the desire of Colorado Medical Society to be as helpful as possible in such public affairs, but to be certain that any such effort be in the best and total interest of all CMS members and component societies. This will take considerable effort on the part of all of the CMS membership.

#### NEW SYSTEM OF COLLECTIONS INSTITUTED IN COLORADO MEDICAL SOCIETY

The Colorado Medical Society has announced an agreement with the I.C. System, Inc., of St. Paul, Minnesota, to help physicians and others in the medical profession deal with the growing problem of customer/patient non-payment of bills.

In taking the action at their May Board meeting, Colorado Medical Society joined 15 other state medical organizations as well as 22 businesses within Colorado in the use of this service.

I.C. Regional Manager John Pie explained that his company has been very successful in getting customers to take care of their financial obligations.

Information published by the company indicates that the telephone is one of I.C.'s most effective tools. It is used to persuade rather than alienate. Harassment or verbal abuse approaches are not only illegal, but often counterproductive.

Pie said employees of I.C. System are not paid on a commission basis but are salaried - thus limiting the financial pressure to perform in a manner that might antagonize the debtors.

There are signs that physicians are encountering problems in eliciting payments from patients. An opinion sampling of 1,000 office-based physicians conducted late last year by the AMA showed that collection problems materialized for 16.1% of those who replied, corresponding with the worsening economic picture across the country.

COLORADO MEDICINE will, in future publications, be explaining in detail the methods by which CMS members will be able to utilize I.C. System, as well as the benefits of this new society-wide service.

#### PRACTICAL NEUROLOGY FOR THE INTERNIST AND FAMILY PHYSICIAN

An intensive, three-day course, offering 16 Category I hours of credit, will be given at Aspen, Colorado, June 28-30, 1980. This course will cover the diagnosis and treatment of common neurological disorders seen by non-neurologists.

For those of you not familiar with Aspen in the summer, you'll find this to be a thoroughly enjoyable way to earn the credits while you and members of your family absorb the leisure of wonderful mountain living in the height of the summer. Aspen, Colorado, changes to summer dress and becomes a different world from that of wintertime Aspen. Many leisure activities await you, and there's no better time than late June to visit Aspen in the summer.

For information and registration, contact the Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 East 9th Avenue, Denver, CO 80262, telephone (303) 394-5241.

#### HELMET PETITION DRIVE

The Motorcycle Helmet Petition drive swings into its final stages. Get your last-minute signatures now. If you are unable to fill each line send in what you have before June 16th. Every signature counts!



## COMING DAYS ARE BUSY DAYS FOR DENVER MEDICAL SOCIETY

The Denver Medical Society has been designated by the American Medical Association to assist the AMA's National Planning Committee in a pilot project in Denver to devise solutions to some of the health care problems of business and industry. This project is an extension of the AMA Corporate Visitation Program. Similar efforts are being made in Birmingham, Alabama; Nashville, Tennessee; Louisville, Kentucky; and Tampa, Florida.

Four Denver Medical Society physicians will be appointed and four local business leaders will be selected to form a steering committee to work with the AMA National Planning Committee. One or two major problems that are amenable to change will be selected for action. Other groups that will be consulted are government, labor, hospitals, etc. A conference will then be called to discuss, analyze and, hopefully, arrive at solutions to these problems.

Since the inception of its Corporate Visitation Program in June, 1978, the AMA has visited the headquarters of 94 leading firms such as General Motors, Hewlette-Packard, Standard Oil of California and Ford Motor Company.

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The Committee on Mental Health of the Denver Medical Society has been studying the problems of chronic mental patients in Denver. An interim study committee has been set up by the Colorado Legislature to review the mental health program this summer. The DMS Committee will be monitoring the deliberations of this interim study committee and plans to testify. The Committee also will be publishing its recommendations for an ideal mental health program for Denver.

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A questionnaire for physicians has been developed by the Committee on Alcohol and Drug Abuse of the Denver Medical Society and is being selectively distributed at hospital staff or section meetings in preparation for the development of an educational program for physicians. The objective is to raise the level of physician awareness in problems of alcohol and drug abuse in adults and adolescents.

The simple one-page multiple choice questionnaire asks each physician to check areas of interest, such as how to discuss alcoholism or drug abuse with patients who deny the problem, recognition of signs/symptoms of alcoholism and drug abuse, identifying and managing the patient who seeks prescriptions of controlled substances from numerous physicians, etc.

The questionnaire is distributed and collected during the meeting, with close to 100% of the attendees responding.

## FUNDING FOR COLORADO DEPENDENT AND NEGLECTED CHILDREN

Unless legal representation for dependent and neglected children is supported by adequate funding, the problems of the abused child cannot be effectively addressed, the Colorado Commission on Children and Their Families has reported.

The Commission has been reviewing Colorado statutes in a time when child abuse and neglect has increased, and state responsibility for such cases needs to be explored.

Amendments in 1967 to the Children's Code allow for appointment of a guardian ad litem to protect the interest of a child in dependency and neglect hearings. The Child Protection Act of 1975 has strengthened these powers but it has been found that without funds to empower appointments of guardians ad litem the Code has less than total effectiveness.

This guardian is usually an attorney, empowered to conduct an investigation and obligated to do everything to represent the child, short of actually filing criminal charges against the responsible party. This individual will have been involved in the care immediately upon the report of abuse, and is responsible both on long-term and short-term bases for the appropriate placement of the child.

The degree of involvement is usually in direct proportion to the severity of the case, which may go on for some years.

The Commission believes the need is to make the responsibility worth while to the lawyer who often has neither the special training nor the experience to interest him in such guardianship.

Because the University of Denver Law School's internship program has been discontinued for lack of funds, such preparation now is lacking. This program should be constituted, and continuing education courses should be expanded and required for all attorneys serving as guardians ad litem.

There are problems when young, inexperienced attorneys sign up as guardians ad litem so that they can have courtroom experience and quit the program early with disastrous results for the children.

The Commission has recommended creation of a task force which has now been formed, and consists of members of the National Association of Counsel for Children, Legal Aid Society, the Colorado Bar Association, and Advocates for Children Today, Denver Chapter. Both long and short-term solutions are anticipated with the goal of making actual representations of the child equal to the intent of the law.



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# board of trustees condensed minutes

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MAY 23, 1980

1. Approved minutes of April 16 meeting of the Board of Trustees, and minutes of the Executive Committee of the Board held May 16, 1980.
2. Approved check register and financial reports.
3. Approved a CMS Travel Reimbursement Policy.
4. Approved Guidelines for Financial Contributions/Sponsorship and Endorsement.
5. Approved reimbursement formula for faculty for Annual and Interim Session educational programs, as well as proposed budget for the 1980 Annual Session Scientific Program.
6. Withdrew previous authorization for release of accreditation data to the new Liaison Committee on Continuing Medical Education.
7. Approved submission of resolution to the AMA entitled "Reimbursement for Drug and Medicine Charges in Voluntary Home Treatment of Terminally Ill."
8. Discussed distribution of moneys to physicians for services rendered to Medicaid patients by the Department of Social Services and/or Joint Budget Committee. It was agreed to move toward equalization of percentage of charges with no decreases; further, that the CMS attorney be instructed to explore the possibility of legal recourse.
9. Approved Guidelines for CMS Delegates and Staff at AMA Interim and Annual meetings.
10. Approved Annual Session dates through 1985.
11. Reviewed the agenda of the upcoming COMPONENT SOCIETY OFFICERS MEETING to be held June 20.
12. It was announced that Mr. Raymond Cunningham is leaving CMS to accept the position of Director of the Office of Medical Society Relations at the AMA, Chicago, effective July 7, 1980.
13. It was reported that Mr. Peter Samac will continue as Executive Director of the Colorado Foundation for Medical Care.

MEMBERS PRESENT:      President:              Ray G. Witham, M.D.  
                         President-elect: K. Mason Howard, M.D.  
                         District II:            Abraham Kauvar, M.D., Frederick Lewis, M.D.,  
   Joseph Poynter, M.D., Wilfred Stedman, M.D.  
                         District III:           J. Richard Brusenhan, M.D., Amilu S. Martin, M.D.  
                         District IV:           Jan Hildebrand, M.D.

MEMBERS ABSENT:      District I:              David Bates, M.D., Merlin Otteman, M.D.  
                         (excused)      District II:            Jerry J. Appelbaum, M.D., William E. Jobe, M.D.  
   Philip Norton, M.D.  
                         District IV:            Hanns C. Schwyzer, M.D.  
                         District V:            Telford Davis, M.D., Robert Linnemeyer, M.D.

## COLORADO INTERNIST NAMED PRESIDENT OF NATIONAL MEDICAL SOCIETY

John F Farrington, MD of Boulder, Colorado, has assumed the presidency of the American Society of Internal Medicine (ASIM) at the group's Annual meeting May 15-18 in Washington, D.C.

Dr. Farrington's duties as President will include presiding over the meetings of the ASIM Board of Directors. He will hold the post for one year. Dr. Farrington has previously served as a member of the ASIM Board of Trustees between 1973 and 1979. He played a key role in developing the American Medical Association's Current Procedural Terminology-4 (CPT-4) system of coding and terminology which was developed for and by practicing physicians. Dr. Farrington was chairman of the CPT Editorial Board, which was charged with keeping the CPT-4 up-to-date.

ASIM, a federation of 51 component societies representing 17,000 internists nationwide, is concerned with the social, political, and economic aspects of medical care delivery.

Dr. Farrington, a native of Boulder and in private practice there in 1956, received his MD degree from the University of Colorado School of Medicine in 1952. He was a fellow at the Cleveland Clinic from 1954-1956. He is a fellow of the American College of Chest Physicians and the American College of Physicians, is on the staff of both Boulder hospitals, and is assistant clinical professor of medicine at the University of Colorado School of Medicine.

## NO LOAN FUND SHORTAGE

During April, 1980, according to George Arden, Executive Director of the American Professional Practice Association, nationwide organization of more than 47,000 physicians and dentists, applications for loans in excess of \$10,500.00 were accepted from APPA members.

An APPA sister organization, the National Association of Residents and Interns, also was a source of further loan applications.

As of mid-April, \$18 million in loans had been extended with the probability that total funds made available for loans through the actual lending company, Associates Financial Services Corporation, South Bend, Indiana, would better \$60 million.

APPA Director Arden stated he had been assured by Associates that no shortage of funds does exist, and that close to 25% of all young doctors entering internships will be receiving Associates support.

Plans Administrator for Associates is Physicians' Planning Service Corporation, with 150,000 physician-dentist members and with offices in over 100 communities.

Denver area representatives are Howard A. Patz, Jim Niemyer, and Morton Brooks. They may be reached at (303) 393-0134.



# CONTINUING MEDICAL EDUCATION CALENDAR

PUBLISHED JOINTLY BY THE COLORADO FOUNDATION FOR MEDICAL CARE, COLORADO MEDICAL SOCIETY AND THE COLORADO ACADEMY OF FAMILY PHYSICIANS • 1601 EAST NINETEENTH AVENUE, DENVER, COLORADO 80218

## JUNE 1980

### 7th

**DOWN'S SYNDROME WORKSHOP & DINNER.** Denver. Contact: Colorado Child & Adolescent Society, 1601 E. 19th Ave., Denver, CO 80218. 861-1221, ext. 241.

### 9th-14th

**26th ANNUAL FAMILY PRACTICE REVIEW.** Estes Park, Colorado. Contact: Office of Postgraduate Medical Education, University of Colorado Health Sciences Center, 4200 E. 9th Ave., Denver, CO 80262. 394-5241.

### 13th

**HEMATOLOGY/ONCOLOGY.** Denver. Contact: Office of Postgraduate Medical Education, University of Colorado Health Sciences Center, 4200 E. 9th Ave., Denver, CO 80262. 394-5241.

### 19th

**COMMON RASHES.** Vail. Contact: Martin J. Rubinowitz, M.D., The Denver Clinic, 701 E. Colfax Ave., Denver, CO 80203. (2 hours of AMA Category 1 credit; 2 prescribed hours of AAFP credit).

### 22nd-26th

**3RD INTERNATIONAL SYMPOSIUM: CANCER THERAPY BY HYPERTHEMIA, DRUGS & RADIATION.** Colorado State University, Fort Collins. Contact: W. C. Dewey, Ph.D., Department of Radiology & Radiation Biology, Colorado State University, Fort Collins, CO 80523. (303) 491-5096.

### 25th

**COLORADO REGIONAL NEURORADIOLOGY & COMPUTERIZED TOMOGRAPHY MEETING.** University Hospital, Denver. Contact: Leatha Kibel, Department of Radiology, University Hospital, 4200 E. 9th Ave., Denver, CO 80262. 394-7773. (3 hours of AMA Category 1 credit).

### 28th-30th

**PRACTICAL NEUROLOGY FOR THE INTERNIST AND FAMILY PHYSICIAN.** Aspen. Contact: Office of Postgraduate Medical Education, University of Colorado Health Sciences Center, 4200 E. 9th Ave., Denver, CO 80262. 394-5241. (16 hours AMA Category 1 credit).

### 30th-July 3rd

**CACMLE POSTGRADUATE CONFERENCE IN CLINICAL LABORATORY PRACTICE.** Hilton Harvest House, Boulder. Contact: Elmer W. Koneman, M.D., Colorado Association for Continuing Medical Laboratory Education, Inc. (CACMLE), 1601 Milwaukee St., Denver, CO 80206. (303) 321-1734.

## JULY 1980

### 2nd-5th

**ASPEN SYMPOSIUM ON AGING.** Continental Inn, Aspen. Contact: Aspen Symposium on Aging, Department of Communications Disorders, Area of Audiology, University of Northern Colorado, Greeley, CO 80639. 351-2012 (AMA Category 1 Physician Award Credit).

### 7th-10th

**OPHTHALMOLOGY: "PROBLEMS IN PEDIATRIC OPHTHALMOLOGY".** Vail. Contact: Office of Postgraduate Medical Education, University of Colorado Health Sciences Center, 4200 E. 9th Ave., Denver, CO 80262. 394-5241. (16 hours AMA Category 1 credit).

### 7th-11th

**16TH ANNUAL POSTGRADUATE COURSE IN INTERNAL MEDICINE.** Estes Park, Colorado. Contact: Office of Postgraduate Medical Education, University of Colorado Health Sciences Center, 4200 E. 9th Ave., Denver, CO 80262. 394-5241.

### 13th-15th

**HOSPITAL MEDICAL STAFF CONFERENCE AND HOSPITAL TRUSTEE FORUM ADVANCED SEMINAR.** Denver. Contact: Estes Park Institute, P.O. Box 400, Englewood, CO 80151. 761-7709.

### 16th-20th

**SUMMER SKIN SEMINAR.** Aspen. Contact: Office of Postgraduate Medical Education, University of Colorado Health Sciences Center, 4200 E. 9th Ave., Denver, CO 80262. 394-5241.

### 18th-20th

**CURRENT TOPICS IN ANESTHESIOLOGY: PHARMACOLOGY FOR THE YOUNG & OLD.** Keystone. Contact: Office of Postgraduate Medical Education, University of Colorado Health Sciences Center, 4200 E. 9th Ave., Denver, CO 80262. 394-5241.

### 21st-24th

**PRACTICAL GASTROENTEROLOGY FOR THE PRACTICING PHYSICIAN.** Aspen. Contact: Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 E. 9th Ave., C-295, Denver 80262. 394-5241. (15 hours of AMA Category 1 credit).

### 21st-25th

**INTERNATIONAL SYMPOSIUM ON HAND SURGERY — COMPREHENSIVE CARE OF THE DISEASED AND INJURED UPPER EXTREMITY.** Keystone. Contact: John A. Boswick, Jr., M.D., Course Director, 4200 E. 9th Ave., Box C-309, Denver 80262. 394-8718. (22 hours of AMA Category 1 credit).

**23rd**

**COLORADO REGIONAL NEURORADIOLOGY AND COMPUTERIZED TOMOGRAPHY MEETING.** Department of Radiology, University Hospital, Denver. Contact: Leatha Kibel, 394-7773. (3 hours of AMA Category 1 credit).

**31st-August 3rd**

**PEDIATRICS.** Snowmass. Contact: Office of Postgraduate Medical Education, University of Colorado Health Sciences Center, 4200 E. 9th Ave., Denver, CO 80262. 394-5241.

**AUGUST 1980****1st-3rd**

**COLORADO ACADEMY OF FAMILY PRACTICE ANNUAL MEETING.** The Lodge, Vail. Contact: Shirlee Meyers, 1570 Humbolt St., Denver. 837-0757. (11 prescribed hours of AMA Category 1 credit).

**2nd-6th**

**PATHOLOGY IN OBSTETRICS AND GYNECOLOGY.** Aspen. Contact: Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 E. 9th Ave., C-295, Denver 80262. 394-5241. (28 hours of AMA Category 1 credit).

**3rd-7th**

**PERINATAL MEDICINE.** Snowmass. Contact: Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 E. 9th Ave., C-295, Denver 80262. 394-5241. (21 hours Category 1 credit).

**6th-10th**

**DYNAMIC PSYCHOTHERAPY: THE CONCEPT OF COUNTERTRANSFERENCE AND ITS RELATIONSHIP TO PSYCHOTHERAPEUTIC PROCESS.** Aspen. Contact: Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 E. 9th Ave., C-295, Denver 80262. 394-5241. (17 hours of AMA Category 1 credit).

**11th-15th**

**ASPEN CONFERENCE ON PEDIATRIC DISEASE, 1980-LUNG.** The Gant, Aspen. Contact: J. Thomas Stocker, M.D., Department of Pathology, Children's Hospital, 1056 E. 19th Ave., Denver, CO 80218. 861-6712. (25 hours of AMA Category 1 credit).

**15th-20th**

**PRIMARY CARE ORTHOPEDICS.** Aspen. Contact: Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 E. 9th Ave., C-295, Denver 80262. 394-5241. (23 hours of AMA Category 1 credit).

**20th**

**WORKUP OF SUSPECTED AND PROVEN MALIGNANT DISEASES.** Aspen. Contact: Martin J. Rubinowitz, M.D., The Denver Clinic, 701 E. Colfax Ave., Denver 80203. (2 hours of AMA Category 1 credit; 2 prescribed hours of AAFP credit).

**21st**

**ANTICOAGULANTS - WHAT YOU SHOULD KNOW.** Vail. Contact: Martin J. Rubinowitz, M.D., The Denver Clinic, 701 E. Colfax Ave., Denver 80203. (2 hours of AMA Category 1 credit; 2 prescribed hours of AAFP credit).

**27th**

**COLORADO REGIONAL NEURORADIOLOGY AND COMPUTERIZED TOMOGRAPHY MEETING.** Department of Radiology, University Hospital, Denver. Contact: Leatha Kibel. 394-7773. (3 hours of AMA Category 1 credit).





**Members of Blue Ribbin Panel, (l to r) Rep. John Davoren, Sen. Bob Allshouse, Rep. Ann Gorsuch, Stan Johnson and Paul Schauer.**

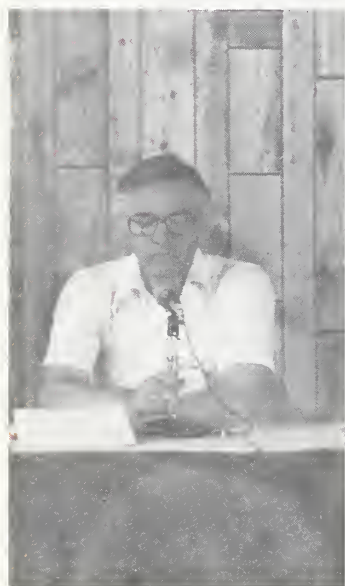
**Fred A. Lewis, MD, talks about cost containment.**



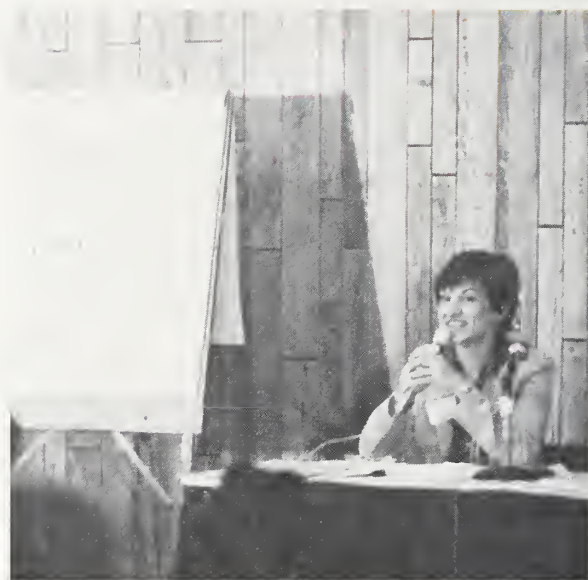
**Pete Gorsuch, husband of Rep. Ann Gorsuch, CMS Board member Hann Schwyzer, MD, Trinidad, Robert Jardine, MD, Denver, Angeline Heaton, MD, Denver.**



Sen. Wm. Hughes and Rep. Robert Shoemaker (Canon City).



Parker Preble, MD, Fort Collins, listening to challenge.



Mary Jean Berg, MD, on "Cost" panel.

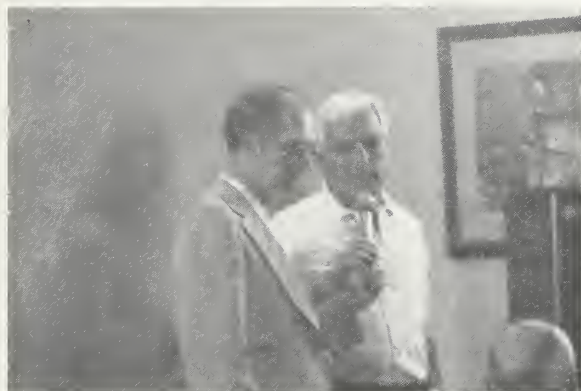


(L to R) Drs. Berg and Preble, with Sen. Hughes and Rep. Shoemaker.





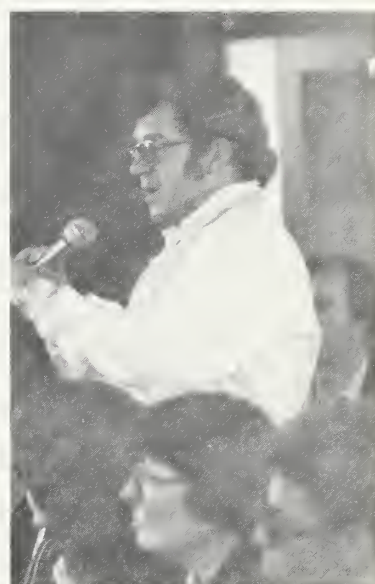
**Drs. Berg and Preble listen to another audience challenge.**



**Moderator Pierson listens as Jerry Lynch challenges panelist.**

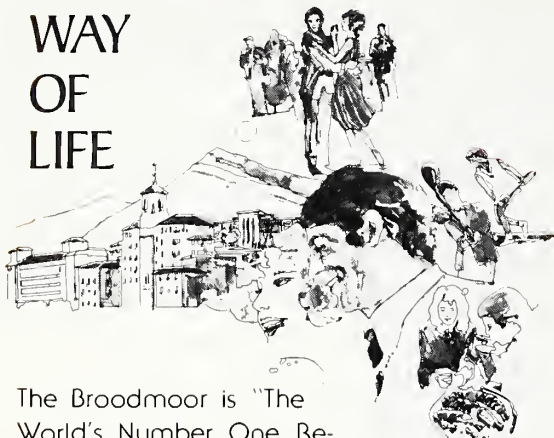


**Sen. Hughes, Dr. Preble, Sen. Ted Strickland, Westminster, and Rep. Steve Durham of Colo. Spgs.**



**Pat Moran, MD, Grand Jct. asks question of panel about HMOs.**

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## Cost Containment Studies Planned

April 25th marked the first meeting of a steering committee to structure a medical cost containment course at the University of Colorado Health Sciences Center. The committee hopes to complete its work sometime next fall.

Participants represent the faculty at the School of Medicine and school of Health Administration, Residents, Medical Students, Colorado Medical Society, Colorado Blue Cross/Blue Shield, CEIS and Denver General Hospital.

Dr. Carlos Martini currently chairs this group.

## Handbook for Continuing Medical Educators To Be Available

### HANDBOOK FOR CONTINUING MEDICAL EDUCATORS



Colorado Medical Society  
University of Colorado Health Sciences Center  
Colorado Consortium for Medical Care

A *Handbook for Continuing Medical Educators* will be published this month as an aid to all those involved in CME who are interested in evaluating and possibly upgrading their own CME programs.

The handbook is a service of the Colorado Consortium for Continuing Medical Education, developed in 1978 as a pooling of the talents and interests of the Colorado Medical Society, the Colorado Foundation for Medical Care, and the University of Colorado Health Sciences Center, its sponsors.

To obtain a copy, phone Kevin Bunnell, EdD, Director, Colorado Consortium for Continuing Medical Education, (303) 861-1221, X 262 (In Colorado, but outside Denver metro area phone 1-800-332-4150) or clip and return the form below:

Dr. Bunnell,

I am interested in the *Handbook for Continuing Medical Educators*. Please get in touch with me at (phone) \_\_\_\_\_

Or write to me: \_\_\_\_\_

Contents include such topics as Finding Out What Education is Needed, Choosing the Right Methods for Teaching and Learning, Evaluating The CME Teacher, Evaluating the Effect of an Educational Program on Participants, and Using a Patient Data System to Plan and Evaluate Continuing Medical Education. A listing of CME resources is also included. PRICE: \$9.00



# Physician assistant/nurse practitioner

## *To Be or Not To Be in Colorado*

David W. Hudgel, MD, Denver, Colorado

In the past year or more one of the major issues addressed by various committees and members of the Colorado Medical Society (CMS) has been the recommended and proper role for nurse practitioners and physician assistants in the practice of primary care medicine. On one hand, some criticize the use of *any* non-physician to deliver *any* aspect of medical care to patients; and on the other hand, some would support independent practice for these practitioners.

Obviously, both of these positions are extreme; the real solution to the proper utilization of "physician extenders" lies somewhere between these two arguments.

In listening to many discussions on this issue, I have made three basic observations: 1) most physicians address this issue emotionally, not objectively. 2) few of us are aware of, the level of quality performance provided by these practitioners. 3) few are talking from the personal experience of having worked with these extenders. I hope by summarizing available information which evaluates the performance of these "para-professionals", and by adding a few personal observations, to help members of the CMS and other physicians develop realistic guidelines for the accepted use of nurse practitioners and physician assistants.

Several well-designed studies have been done within this decade, and I would like to review them. I have purposely reviewed only articles in refereed medical journals, since these manuscripts would receive the most critical review prior to publication.

### *Nurse Practitioners*

One of the first studies appeared in the *New England Journal of Medicine* in 1971. Charney *et al.* evaluated the performance of nurses working in a large pediatric practice.<sup>1</sup> The four

nurses evaluated had received only four months of pediatric training prior to the study. As newborn infants entered the practice they were assigned alternately to a nurse or pediatrician for well-baby care over the first two years of life. The only quality assessment measurement in this study was a comparison of the number of office visits needed for illness by babies cared for by nurses and those cared for by the pediatricians. After two years there was an equivalent number of these office visits needed by the babies of each group, indicating that the nurses had provided adequate preventive and educational services to babies and their mothers in this relatively healthy population. In addition, mothers were quite satisfied with the nurses' performance. This study would imply that most well-baby care can be delivered by minimally but properly trained health care workers.

What about nurse practitioner performance in the treatment of minor acute illnesses? In 1975 Greenfeld *et al.* evaluated the performance of nurses working with protocol for low-back pain.<sup>2</sup> In a large health maintenance organization, over 400 patients were randomly assigned to nurses and physicians for evaluation and treatment. With the protocol nurses could independently manage 53 per cent of their group. There was no difference in symptomatic relief four months later in the patients they managed when compared with those cared for by physicians. Patients were as satisfied with nurse care as with physician care. Greenfield *et al.* also evaluated nurses working with a headache protocol.<sup>3</sup> The study design was similar to that used in the back pain study. Nurses were able to independently manage over half of the 203 headache patients assigned to them. Four months later patients cared for by nurses and physicians reported an equal amount of improvement. Again, patients cared for by the nurses were very satisfied. Winickoff *et al.*

evaluated nurse care of minor respiratory illnesses by examining the performance of three nurses over a 12 week period of time.<sup>4</sup> There was also a comparison made between nurses who used a protocol with those who did not. Nurses and physicians agreed on diagnosis and physical findings in at least three-quarters of the patients. Nurses who used a protocol performed better than those who did not in that there was less inappropriate use of antibiotics and fewer revisits by their patients.

One of the most complete studies was done by Chambers *et al.*<sup>5</sup> The authors evaluated the impact of family nurse practitioners on the volume, quality, and cost of rural health care practice. Over 2000 residents of two small villages were randomly assigned to family nurse practitioners or to physicians for care over a one year period. The care delivered for twelve indicator diagnoses and the use of fourteen drugs were audited based on predefined criteria. Family nurse practitioners were judged to have delivered care equivalent to that of physicians. There was an equal amount of proper drug use by nurses and physicians. In addition to equivalent quality of care, there was a 5 per cent decrease in hospital days for acute illnesses in the nurse-managed group, but a 40 per cent increase in the physician-managed group.

These studies demonstrate that nurse practitioners perform quite well in both health maintenance and minor illness care, especially when working with a protocol. By increasing ambulatory care activity and preventive services, and thereby decreasing hospital days, these practitioners may help decrease medical care costs.

#### *Physician Assistants*

Several studies have been published evaluating the performance of physician assistants. Kane *et al.* studied the quality of care delivered by two graduates of the Utah Medex program compared with that delivered by three family practice residents and six faculty members over a nine month period of time in treating 1,761 episodes of acute illness presenting to an outpatient facility.<sup>6</sup> Outcome of treatment was equal in Medex and physician treated groups, regardless of the severity of the initial presentation. Patient satisfaction was actually somewhat better in the Medex group. The same authors also evaluated Medex performance in thirteen rural medical practices.<sup>7</sup> Physician

assistants performed equal to physicians in the care of five monitored diagnoses. Komaroff *et al.* evaluated physician assistant and physician care of diabetes and hypertension over an 18 month period of time.<sup>8</sup> Control of blood pressure and blood sugar was equal in two groups. By their participation in this practice, physician assistants saved physicians considerable time. There was equivalent cost and patient satisfaction with the two forms of care. Tomkins *et al.* also examined the care given by five physician assistants to hundreds of patients presenting with acute respiratory tract illnesses.<sup>9</sup> Again, the outcome was equivalent in the physician assistant and physician treated groups.

Greenfield *et al.* did a time and cost analysis of both physician assistants and nurse practitioners in their treatment of urinary tract infections, upper respiratory tract illnesses, headache, and abdominal pain.<sup>10</sup> Results showed that there was a 92 per cent savings in physician time required for evaluation of patients with these problems. The cost of physician assistant or nursing visits was 20 per cent less than physician visits due to the ordering of fewer laboratory tests. The above reviewed studies show that physician assistants can deliver a high quality of patient care, and save the physician a considerable amount of time at a cost that is acceptable.

There were no studies found demonstrating poor or inferior performance by nurse practitioners or physician assistants. By utilization of these practitioners, the physician can be freed of routine duties to concentrate on the more difficult, interesting patient problems he sees in his practice. I hope physicians, especially those working in medically underserved areas, will be able to utilize qualified physician assistants or nurse practitioners to help provide health care services to a larger population base. In Colorado, many rural physicians and rural communities might benefit from these providers.

In visiting and working in several private practice and public clinic settings in urban and rural Colorado communities, I have observed a high caliber of care delivery and humane concern given by nurse practitioners and physician assistants. Yes, these individuals do need our assistance and advice; but they are more capable, talented, and concerned than we often give them credit for. The nurse with whom I work proves this to me daily! ●



## REFERENCES

- <sup>1</sup> Charney, E., and Kitzman, H.: The Child-Health Nurse (Pediatric Nurse Practitioner) in Private Practice. *N Engl J Med* 2S5:1353-1358, 1971.
- <sup>2</sup> Greenfield, S., Anderson, H., Winickoff, R.N., Morgan, A., and Komaroff, A.L.: Nurse-Protocol Management of Low Back Pain. *West J Med* 123(5):350-359, 1975.
- <sup>3</sup> Greenfield, S., Komaroff, A.L., Anderson, H.: A Headache Protocol for Nurses. *Arch Intern Med* 136: 1111-1116, 1976.
- <sup>4</sup> Winickoff, R.N., Ronis, A., Black, W.L., Komaroff, A.L.: A Protocol for Minor Respiratory Illnesses: An evaluation of its use by nurses in a prepaid group practice. *Public Health Reports* 92(5):473-480, 1977.
- <sup>5</sup> Chambers, L.W., Bruce-Lockhart, P., Black, D.P., Sampson, E., Burke, M.: A Controlled Trial of the impact of the Family Practice Nurse on Volume, Quality, and Cost of Rural Health Services. *Med Care* XV(12):971-981, 1977.
- <sup>6</sup> Kane, R.L., Gardner, J., Wright, D.D., Woolley, F.R., Snell, G.F., Sundwall, D.N., and Castle, C.H.: Differences in the Outcomes of Acute Episodes of Care Provided by Various Types of Family Practitioners. *J Fam Pract* 6(1):133-138, 1978.
- <sup>7</sup> Kane, R.L., Olsen, D.M., and Castle, C.H.: Medex and Their Physician Preceptors: Quality of Care. *JAMA* 236(22):2509-2512, 1976.
- <sup>8</sup> Komaroff, A.L., Flatley, M., Browne, C., Sherman, H., Fineberg, S.E., and Knopp, R.H.: Quality, Efficiency, and Cost of a Physician-Assistant-Protocol System for Management of Diabetes and Hypertension. *Diabetes* 25(4):297-306, 1976.
- <sup>9</sup> Tompkins, R.K., Wood, R.W., Wolcott, B.W., and Walsh, B.T.: The Effectiveness and Cost of Acute Respiratory Illness Medical Care Provided by Physicians and Algorithm-assisted Physicians' Assistants. *Med Care* XV(12):991-1003, 1977.
- <sup>10</sup> Greenfield, S., Komaroff, A.L., Pass, T.M., Anderson, H., and Nessim, S.: Efficiency and Cost of Primary Care by Nurses and Physician Assistants. *N Engl J Med* 298(6):305-309, 1978.

David W. Hudgel, MD, Denver, Colorado, is Assistant Professor of Medicine, University of Colorado Health Sciences Center and Director of Adult Ambulatory Services, National Jewish Hospital and Research Center; and Chairman, Manpower Committee, Colorado Medical Society.



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| ★ Conditioning Classes  | ★ Social Activities              |
|                         | (ski trips, softball team, etc.) |

# Patient's Records - What Are The Rules?

*Are you confused as to what to do when you have no authoritative source for consistency and reliability? Once again, CMS to the rescue. There seems to be a disease rampant among physicians on what to do with patient records.*

*Brian Stutheit, of the CMS staff, has prepared the following outline on what to do with your private patient records to help you through the "records" minefield. This is the first of two articles on this subject. The second will cover records in institutions and other situations outside the private office.*

*It is designed to be used as a brief reference outline.*

*If you have specifics, call us. That's why we're here.*

**Access/Records in Custody of Individual Health Care Providers:** Colorado law mandates access to patient records in the custody of a health care facility or in the custody of "individual health care providers." "Patient records" do not include a doctor's office notes.

Patients who want to inspect their records must submit a written request, dated and signed, at reasonable times and upon reasonable notice. If the patient wants a copy of the records made available to himself or his designated representative, he must again submit a written authorization, dated and signed by the patient. In addition, the physician may require payment of reasonable costs for the copies. The Colorado Department of Health has issued regulations interpreting the access to records law which define reasonable cost: "The patient or representative shall pay for the reasonable cost of reproduction of his/her patient record, not to exceed \$5.00 for the first ten or fewer pages and \$.25 per page for every additional page." For special records, like x-rays, the physician may charge the actual cost of reproduction.

In most cases, a minor's parent would be considered the natural guardian and thus should be allowed to see the child's record. See the exceptions (not exclusive) below.

Individual physicians need not grant access to records pertaining to psychiatric problems or to records that would have a significant negative psychological impact upon the patient, but may be required to make available a summary of those records. Similarly, the law is not construed to require the release of records of diagnosis and treat-

ment of venereal disease or drug addiction to a parent or guardian when the patient is a minor.

Requests by patients for inspection of their medical records should be noted with the time and date of the request and the time and date of inspection.

The position of the Colorado Medical Society Grievance Committee and the AMA Judicial Council is that it is improper to withhold patients' records on the basis of non-payment of bills. There are other means of collection and the public relations damage from this type of action outweighs any advantages accruing on an economic basis.

Special federal rules apply to alcohol and drug abuse records kept in connection with a federally assisted function.

Senate Bill 91, which became law in 1976, authorizes committees of the State Medical Society to request written permission from physicians to examine charts for the adequacy of medical care.

**Retention:** By regulation, patient records in the custody of a health care facility must be retained at least 10 years. Minors' records are retained longer. There is no such requirement for records preservation by individual health care providers.

The statute of limitations for negligence, breach of contract, or lack of informed consent suits is an important consideration in record keeping by individual physicians. It is important to consult one's own attorney to tailor a retention plan to fit particular needs.

As a general rule, suits against Colorado physicians for negligence, breach of contract or lack of informed consent must be instituted within two (2) years after the person bringing suit discovered, or reasonably should have discovered, the injury. An action may not be instituted more than three years after the complained of conduct, regardless of time of discovery.

However, there are numerous circumstances where the time limit is extended. Where the suit is by certain patients who were minors at the time of the act or omission leading to suit, then the period is extended. If a foreign body was left in a patient, the statute may be extended. A physician's concealment of an act or omission may extend the statute of limitations. These intricacies account for the need to consult an attorney about retention.

If storage is a problem, reproducible microfilms may be made. There are companies that will photograph and store records for you.



## new members

**El Paso County Medical Society:** Elmore J. McCarty, Andrew W. Mitchell, Jay L. Adler, and James K. Blixt.

**Adams-Aurora Medical Society:** Marvin L. Swanson.

**Mt. Sopris County Medical Society:** Roland W. DeYoung and James A. O'Donnell.

**Curecanti Medical Society:** Charles E. Schaefer.

**Boulder County Medical Society:** Charles G. Jones, Susan L. Bunnell, James E. Ehrlich, and Clarence A. Griffin.

**Clear Creek Valley Medical Society:** Eric A. Eisenbud.

**Delta County Medical Society:** Allen Edson Workman.

**Weld County Medical Society:** Peter A. Kuhl, Michael R. Paddock, John Emil Raeder, and Glen R. Stream.

### Kellogg Grant to Denver Medical Scholar

Jeffrey C. Bauer, PhD, of Denver, whose article "An Economist Looks at Rural Health Care" in the *Rocky Mountain Medical Journal* for November 1974, was a notable description of the rural health care dilemma, has been awarded a Kellogg National Fellowship.

The grant is a three-year grant, of which 42 were distributed nationally. It is as part of the Kellogg Foundation's 50th Anniversary observation that the awards were made. Basis of selection was each individual's outline of a non-degree, self-directed study component he would pursue as a broadening of the individual's perspectives of people, places, and ideas.

Bauer has been an Associate Professor of Economics and a Health Program Adviser at the University of Colorado Health Sciences Center, and is one of the first professional economists to apply economic analysis to the field of dental care.

## **WE'RE AMAZED THAT SOME FOLKS STILL BUY AND MAINTAIN THEIR AIRPLANES ON THE BASIS OF THE LOWEST BID. THEY EVEN APPROACH THEIR FLIGHT TRAINING IN THE SAME WAY. WE THINK IT'S VERY UNPROFESSIONAL.**

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# Ureteral colic in a young man

## *Idiopathic Retroperitoneal Fibrosis Involving the Bladder and Rectosigmoid*

Waldemar Klimach, MD, Jeffrey R. Woodside, MD, and Thomas A. Borden, MD,  
Albuquerque, New Mexico

*A case of extensive retroperitoneal fibrosis involving the rectosigmoid mesentery, bladder and retroperitoneum to the level of the renal pedicles is presented. The unusual clinical presentation and radiographic findings are discussed. Management included exploratory laparotomy, multiple deep biopsies, and extensive urinary tract reconstruction.*

Albarran<sup>1</sup> first described retroperitoneal fibrosis in the French literature in 1905. It was popularized as a clinical entity by Ormand<sup>2</sup> in 1948, and nearly 500 cases have subsequently been reported. Methysergide ingestion is associated in 12 per cent of the cases of retroperitoneal fibrosis, and malignancies in 8 per cent.<sup>3</sup> In the majority of cases, the etiology is unknown and is termed idiopathic.

Idiopathic retroperitoneal fibrosis (RPF) rarely violates the true pelvis. A literature review disclosed 12 cases of RPF involving the bladder and 6 the rectosigmoid but only one case involving both the bladder and the rectosigmoid. The unusual clinical presentation and extensive rectosigmoid and bladder involvement in our patient prompts this case report.

### CASE REPORT

A 26-year old man presented with dysuria, gross hematuria, fever, malaise and right sided colic. An intravenous pyelogram demonstrated mild right hydroureteronephrosis. He was treated conservatively for a probable ureteral calculus. These symptoms subsequently recurred and he in addition described weight loss, constipation, and small caliber stools. He had no history of methysergide ingestion. The pertinent physical findings were diffuse lower abdominal and pelvic firmness with no discrete mass, and moderate suprapubic tenderness. Laboratory values were normal with the exception of mild anemia. He had a sterile urine culture. An intravenous pyelogram showed bilateral hydroureteronephrosis to the pelvic brim and suggested medial displacement of the right ureter (Fig. 1). A right retrograde pyelogram demonstrated no intrinsic ureteral obstruction and confirmed medial ureteral deviation (Fig. 2). A left retrograde pyelogram could not be obtained because of technical difficulties. On cystography, the bladder appeared to be elevated, displaced anteriorly and extrinsically compressed circumferentially

(Fig. 3). Endoscopic biopsies of an apparent mass at the bladder base showed inflammation but no malignancy. Sonograms suggested a right-sided posterior pelvic mass of mixed sonographic characteristics compatible with an abscess or lymphoma. Barium enema showed the rectum displaced anteriorly and narrowed from extrinsic compression (Fig. 4). Sigmoidoscopy was normal and rectal and prostate biopsies showed no malignancy.



Fig. 1. Intravenous pyelogram showing bilateral hydroureteronephrosis and suggesting medial displacement of the right ureter.



At exploratory laparotomy, an extensive, extremely dense fibrous mass involving the rectosigmoid mesocolon, perivesical space, and the retroperitoneum to the level of the renal pedicles was encountered. Multiple deep biopsies showed proliferating fibroblasts and fibrous tissue replacing the fat, compatible with benign retroperitoneal fibrosis. The extent of the pelvic fibrosis prevented complete ureterolysis and insufficient ureteral length precluded a left ureteroneocystostomy. Therefore, a right psoas bladder hitch was done and a Boari flap was developed. A left-to-right transureteroureterostomy and a right ureteroneocystostomy were then performed. An omental interposition completed the reconstructive procedure. Six months postoperative, an IVP showed resolution of hydronephrosis. He had regained strength and weight and was working fulltime.



Fig. 2. Right retrograde pyelogram demonstrating no intrinsic ureteral obstruction and confirming medial deviation.

## Discussion

The clinical presentation and surgical findings in our patient were atypical of idiopathic retroperitoneal fibrosis in several aspects. He was considerably younger than the usual patient with RPF. While fever occurs in 10 - 16 per cent of patients, it is usually associated with urinary tract infection.<sup>3 4</sup> The reported incidence of hematuria is only 1.4 - 5 per cent and was unexplained in our patient. The presence of easily palpable abdominal and pelvic firmness is unusual and small caliber stools indicative of rectosigmoid involvement are rare. In a young man, this combination of weight loss, malaise, pal-

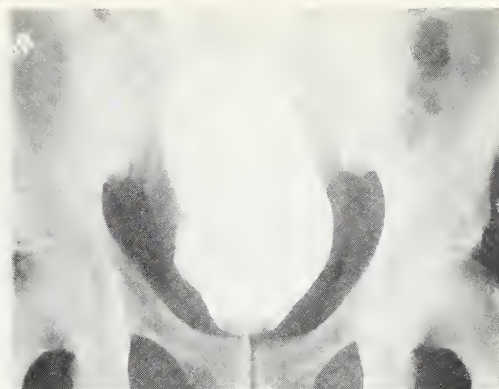


Fig. 3. Cystogram revealing the bladder elevated and extrinsically compressed circumferentially.

pable abdominal and pelvic firmness, small caliber stools, radiographic evidence of extrinsic compression of the rectum and bladder and fever in the absence of urinary tract infection was highly suggestive of a malignant process.

In a necropsy analysis of 40 cases with RPF, Mitchinson<sup>5</sup> observed that the fibrotic process is usually limited to the lumbar periaortic and iliac retroperitoneal space. Extension below the pelvic brim is uncommon. Binder, *et al.*<sup>6</sup>, reported a case of RPF with concomitant retractile mesenteritis in which fibrotic tissue completely filled the retroperitoneum from diaphragm to the pelvic brim, but structures below were spared. To our knowledge, the only previously reported case with both bladder and rectosigmoid involvement was a 25-year-old Negro male with Factor VII deficiency who presented with weight loss and lower abdominal pain.<sup>7</sup> At exploratory laparotomy, the posterior bladder surface, prostate and ureters were intimately surrounded by greyish-white fibrous tissue. Six years later, a barium enema showed extrinsic rectosigmoid compression, similar to that in our case. This patient improved with conservative, nonoperative treatment. Occasionally extensive rectosigmoid involvement requires bowel resection or colostomy.<sup>8 9</sup>

The importance of multiple deep biopsies in establishing the diagnosis of RPF cannot be overemphasized as the association with various malignancies has been well documented.<sup>10 11</sup> Thorough surgical examination of the retroperitoneal space suggested benign RPF in many of these cases, but malignancies were proven on biopsy. This point is further illustrated in the case reported by Trever<sup>12</sup> in which a rectosigmoid resection and colostomy were performed for extensive RPF. The patient did not improve and re-exploration disclosed retroperitoneal reticulum cell sarcoma.

Retroperitoneal fibrosis has been treated by many modalities including irradiation, antibiotics, anti-inflammatory agents, and surgery. Treatment with irradiation and antibiotics has generally been abandoned. In mild cases associated with methysergide therapy, withdrawal of the medication and conservative treatment is often successful. The role of steroid

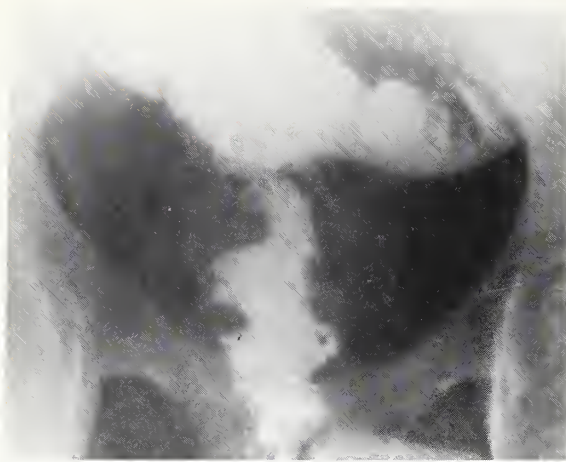


Fig. 4. Barium enema showing the rectum narrowed from extrinsic compression, a finding consistent on all films obtained.

therapy in retroperitoneal fibrosis is controversial. It may be most useful in patients with gastrointestinal tract involvement, significant systemic symptoms, evidence of an active inflammatory process, and the debilitated patient who is a poor surgical risk.<sup>13</sup> However, most patients will require surgical intervention. The passage of ureteral catheters will usually produce immediate improvement in patients with anuria or azotemia. Ureterolysis, sometimes including intraperitoneal placement of the ureters, is a widely accepted mode of therapy. In cases such as ours with very extensive fibrosis, a variety of reconstructive procedures may be necessary. ●

From: Division of Urology, Department of Surgery, University of New Mexico School of Medicine, Albuquerque. Address reprint requests to: Jeffrey R. Woodside, MD, Division of Urology, University of New Mexico School of Medicine, 2211 Lomas Boulevard NE, Albuquerque, New Mexico 87131.

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## obituaries

Doctor **John Gordon Hedrick** of Wray, Colorado died March 7, 1980 in Mesa, Arizona where he had practiced and lived since 1963.

Doctor Hedrick was born in Wray January 7, 1915, and attended its schools, entering the then Greeley State Teacher's College in 1932 from which he transferred to the University of Colorado for pre-medical schooling. He was graduated from the University of Colorado Medical School in 1941.

He served a two-year rotating internship at the University City Hospitals, Oklahoma City, Oklahoma which was followed by a two-year surgical

residency at Colorado General Hospital, Denver. He then served three years in Denver surgery practice.

In September 1947 he returned to Wray to practice surgery from the Wray Clinic. In 1963 he moved to Mesa, Arizona where he practiced until he retired early in 1980.

He had been a member of the Colorado Medical Society and was a fellow in the American College of Surgeons.

His widow, Geneva, and two sons, Michael of San Francisco and William of Mesa, survive.



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*Record-keeping is a vital part of today's patient care. Just as vital is the knowledge, on the part of the physician, of how these records are to be handled, what the legal responsibilities are in protecting these records. This is the second in a two-part series about "you and the law concerning patient records."*

- 240 LEGISLATIVE SEMINAR A SUCCESS  
*CMS Lobbyist Carol Tempest reviews the May 23-25 Legislative Seminar, held at Vail, Colorado. The seminar received high marks from most participants, and the organizers and facilitators learned some important things about cultivating a healthy, purposeful relationship between the physician and the lawmaker.*
- 246 PHYSICIAN PLACEMENT/RECRUITMENT  
*Is there a doctor shortage in Colorado? Is there a surplus of physicians statewide, or is this merely an attitude created by increased competition, increased pressure on cost-containment, changes in advertising philosophies, or whatever? What is the health/medical care delivery picture in rural areas of Colorado? What is being done to fill a void, narrow the gap, and induce expanded coverage of the medical needs?*
- 250 THE PHYSICIAN FAMILY  
*Someone, whether it be psychologist, psychiatrist, therapist, social worker or concerned family member, has realized that the physician family is a unique grouping of people. There are special circumstances, special pressures and relationships brought on by the physician's profession. That's why this survey concerning the family of the physician is an important part of this edition. Read it . . . and see how your family measures up.*

### THE COVER

*A special story surrounds this month's cover photo of the famous Broadmoor Hotel. You'll find the cover story in our "At Press Time . . ." section.*

Address all correspondence relating to subscriptions, advertising or address changes, manuscripts, organizations and other news items relating to editorial content to Editorial and Business Office.

Editorial and Business Office  
1601 E. 19th Ave.  
Denver, Colorado 80218  
Telephone (303) 861-1221

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*Colorado Medicine* (ISSN-0199-7343) is published monthly for \$12 per year by the Colorado Medical Society, 1601 East 19th Avenue, Denver, Colorado, 80218. Second-class postage paid at Denver, Colorado. POSTMASTER: Send address changes to *Colorado Medicine*, 1601 East 19th Avenue, Denver, Colorado 80218.

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# president's letter

Abraham Kauvar, MD., Director of Health and Hospitals, City of Denver, was kind enough to invite me to a luncheon he gave in honor of the Deputy Mayor of New York City. Also present were members of the New York Department of Health and related agencies of the nation's largest city. The reason for the visit by the New York officials was to look over and through what they consider to be a model health system in a major American city. It is significant in a number of ways that New York looked to Denver for a model: first, New York officials consider Abe Kauvar a worthwhile authority on such a subject that they have had more than one conversation with him, and second, that Abe is not only recognized in this country but abroad as an expert in his field. Following the luncheon in Denver Abe left for Israel to continue his work with that government on a new, country-wide health system plan. Dr. Kauvar had been asked to consult that government, beginning some two years ago, in their effort to devise a health plan.



As I have mentioned in this column previously, Doctor Roy Schwarz, Dean of the University of Colorado School of Medicine, is also serving as a visiting consultant abroad. The government of Saudi Arabia has asked Dean Schwarz to aid in developing medical education in that country. In addition, I must mention University of Colorado President Arnold Weber in this context, as I want to make two points:

1. We are extremely fortunate in our state to have attracted two men of the calibre of Roy Schwarz and Arnold Weber to our educational institutions, along with being lucky enough to have a life-long Colorado resident such as Abe Kauvar. It is my view that there's more than gold in those mountains of Colorado; there's more than one kind of resource: human resources which we can count among our professional wealth.

2. You can say all you want about diplomatic table talk and negotiations with foreign nations, but I believe that the communication we have enjoyed with Saudi Arabia and Israel through Drs. Schwarz and Kauvar have given us a measure of international communication that exceeds anything the diplomats can possibly do. Such efforts we must encourage and applaud.

I had the pleasure of representing you at recent

graduation ceremonies at our school of medicine. Dr. Norman Joseph and I, along with Lt. Governor Nancy Dick and Dean Schwarz did the "hooding" and presented the diplomas. It was an excellent ceremony, and a "tear-jerker" in a way. The Dean reminded the graduates of the tremendous challenges facing the physicians in the years ahead. His message was very effective in its delivery and its content, though I doubt that the graduates grasped the true meaning of his remarks immediately. I believe his words will come back to those people many times in the future. It was that kind of, (and that meaningful), a speech.

The Component Society Officers' Meeting was a marked success for us, and, hopefully, for the persons who attended and participated. The officers and staff are appreciative of the input and the suggestions given us. I assure you that you have an excellent group of people representing all of you, and we look forward to more meetings of this kind.

*Ray S. Weber*



## OUR COVER

Since 1879 when the Colorado Medical Society first met in the Court House Hall at Colorado Springs, the Pikes Peak area has been a popular meeting place. The Broadmoor has been the scene of 15 annual meetings since 1964, with 1980 to be recorded as the 16th annual gathering at this stately pleasure dome.

The Broadmoor was an outgrowth of the Broadmoor Casino, built in 1891 by Count James de Pourtales as a Western Monte Carlo but which failed to arrive and survived only to burn to the ground in 1897. The Count became associated with Richard Penrose, from Pennsylvania, in Arizona mining ventures, and earned enough from this venture to retire to Germany. It was the younger brother of Richard Penrose, Spencer Penrose by name, who created the wonder that is The Broadmoor.



# Patient Records Rules, Part II Institutions and Peer Review,

## Records in Hospital Custody - Retention and Access

Under both state regulation and as a condition of Medicare participation, hospitals are required to have a medical record department which will preserve patient records at least ten years after the last previous patient care. Hospitals are understood to own the records proper and to be custodians over the information in records, with a responsibility to safeguard records against loss and use by unauthorized persons, but they are also obliged to release records to certain parties who show a legitimate interest in their use.

Hospital patients may see their records or obtain copies under much the same procedure as for records in an individual physician's custody. The Colorado law on patient access does not explicitly protect doctors' "notes" that appear in a hospital record. This is in contradistinction to the law on records in the hands of individual practitioners, which protects "doctors' office notes." The Department of Health has concluded, therefore, that doctors' notes are subject to disclosure once entered into the hospital chart. The obvious lesson is that individuals entering a hospital record must use condign language.

It is obvious that hospital records are subject to wider review than records in an office. The hospital may let a whole range of support personnel use the record. The medical staff may evaluate records for timely completion and quality of care (See Colorado Senate Bill 91, 1976). Infection Control and other committees might have access.

## Physician - Patient Privilege

Colorado has a statute (13-90-107 (1979 Supp.)) which says that a physician or surgeon may not be examined without the consent of the patient as to any information acquired in attending the patient which was necessary to enable him to prescribe or act for the patient. This statutory "privilege" is less broad than may be commonly understood.

The privilege applies to judicial or quasi-judicial proceedings - it does not apply across the board. Indeed, the law states specifically that the privilege does not apply to:

1. A physician sued by or on behalf of the patient or his heirs on any cause of action connected with the physician's treatment of the patient.
2. A physician who was in consultation with the physician sued.
3. A review of a physician's services by any of the following:
  - a. The governing board or medical staff of a hospital where the physician practices, pursuant to written bylaws
  - b. an organization authorized by federal or state law or contract to review services, or an organization which reviews the cost or quality of physicians services under a contract with a group health care program
  - c. the state board of medical examiners
  - d. a peer review committee of a medical society whose membership includes not less than one-third of the MD's or DO's licensed in Colorado. The subject physician must be a society member and have signed a release authorizing review. (This is essentially the provision under which the CMS Risk Management Committee operates).
4. A physician or any health care provider who was in consultation and who may have acquired information or records relating to the services performed by the physician specified in subparagraph 3, above.

The privilege belongs to the patient. If the patient expressly or impliedly waives the right to non-disclosure, then the physician may not invoke it.

## Records as Source of Payment

Institutional records are called upon regularly by third party payors as a source of service review and claims processing. This area poses great problems for institutions because so many interests conglomerate - often with disparate needs. The physician may have an interest in the record. The patient does. The third-party payor's needs do not necessarily correspond to those of the patient or physician. On top of its obligations to each of the other parties, the institution might have its own economic interests rolled up with the records.

Because the area is too complex for the space allotted here, I will discuss only release of information to Medicare and Medicaid.

Federal law on Medicare and Medicaid conditions reimbursement upon access. The government

agencies involved and fiscal intermediaries may review the records without patient consent, as long as the use is pertinent to the reimbursement program. The question of the inherent right of government or intermediaries to see records is usually made moot by the fact that beneficiaries sign forms specifically consenting to release.

### **Grievance Committee, Board of Medical Examiners**

The Colorado Medical Society's Grievance Committee occasionally requests records in order to investigate a complaint. The records are obtained by having the patient or complainant sign an authorization for record review. Records thus obtained are used only for the purposes of the Grievance Committee, and contents are not disclosed to third parties. Sometimes, but very rarely, the records are forwarded to the Society's Judicial Council for a full hearing or to the Board of Medical Examiners (BME). The BME is notified when the nature of the alleged offense is such that the Committee cannot deal with it (e.g., claim of manslaughter), or when the investigation leads to a real

belief that the physician has engaged in unprofessional conduct as proscribed in Colorado's Medical Practice Act.

Grievance Committee records are immune to a subpoena in any civil suit against the physician, and the Committee's records are exempted from "any law requiring that . . . minutes or records of the committee with respect to action of the committee taken pursuant to the provisions of this article (C.R.S. 1973, 12-43.5d102, 1978 Repl. Vol.) be open to public inspection."

The BME may request a summary of the findings, recommendations and disposition of Grievance Committee actions. This is also true of medical staff reviews and the actions of a hospital board in regard to recommendations of one of its review committees.

**Brian K. Stutheit**  
**Professional and Patient Relations Division**

If you have any questions about records retention, accessibility, etc., in your office or hospital, call the Colorado Medical Society at 861-1221.

Newly promulgated regulations concerning employer retention of employee medical records were printed in the Federal Register, Number 45 FR-35284, dated May 23, 1980. These regulations state, in brief, that "employer-maintained records of worker medical histories and exposures must be provided upon request." Physicians involved with aspects of occupational medicine may want to contact the federal offices in Denver to determine specific requirements (agent, type of record, retention, etc.).

For such information, contact:

Stanley J. Reno  
Regional Consultant, Occupational Safety and Health  
NIOSH - USPHS  
Room 1194, Federal Building  
Denver, Colorado 80294



# at press time ...

## LEGISLATIVE SEMINAR RECAP NUMBER 2

On a scale of 6 (high) through 1 (low) the Legislative Seminar, held at Vail, Colorado, May 23, 24 and 25, was graded consistently above average by those 40 persons who responded with a written evaluation.

The high point of the two and a half days was the dinner party held Saturday evening. EVERYONE of the respondents said it was a 6. Editorially speaking, that is a good evaluation, because the party gave all of the participants an opportunity to get to know one another better than at any other time during the seminar.

The Government Affairs Division has found a lasting value in the videotapes made in two of the panel discussions in that many people who were not in attendance have been able to share in the seminar in the weeks since. The tapes are still in circulation, and not only within the Colorado Medical Society. Material from the tapes will be used on a number of occasions, through the Annual Session in late September. It should be noted that the video taping was made possible, in part, through contributions from Eli Lilly and Company, Merrell-National Laboratories, The Upjohn Company, and Sandoz Pharmaceuticals.

### Comments from evaluations:

- Suggest narrowing range of topics to be discussed in seminar.
- Suggest breaking up into smaller workshop or panel groups.
- Set time limit on debates....and stick to them.
- Get more people to actively participate in discussions.
- More co-mingling of legislators and medical members.
- Inject controversy, particularly in early stages of program.
- More or broader representation on panels of average, private-practice physicians with legislators.

The overall rating of the legislative seminar was in the upper third, which means that the participants did find value in this type of gathering, and would look forward to participating in future such seminars.

## FIRST SEMI-ANNUAL COMPONENT SOCIETY OFFICERS' MEETING RECAP NUMBER 1

Again, a first of a kind meeting, this one held at the CMS headquarters in Denver on June 20th. All but three of the 30 component societies were represented. Again, majorily, the participants expressed an above-average view of the meeting, its contents, its purpose and its results.

Ray Witham, MD, Colorado Medical Society President, keynoted the session by pointing out those aspects of medical practice and philosophy which are, today, critical points for consideration by Society members, e.g., areas of legal, ethical, educational and scientific developments which the physicians must be closely monitoring.

Society legal counsel Lawrence Wood pointed out that there are three major concerns at the moment: 1) anti-trust laws and medical practice, 2) legal aspects of membership in the Colorado Medical Society, and 3) Immunity of physicians to suits arising out of professional review activities.

Giles Toll, MD, Chairman of the Organizational Study Committee, provided the participants with a succinct view of the updating of CMS By-Laws. Dr. Toll emphasized that the By-Laws needed to be reviewed and changed to make the organization more efficient, in

view of the pace of the new decade of the 80s. Dr. Toll stressed the fact that his committee went to great lengths to protect the interests of all members and components of CMS and to see that changes to the By-Laws would not be deliterious to the thrust of the Society, as a whole.

Robert Sawyer, MD, Chairman of the Board of the Colorado Foundation for Medical Care, outlined the new thrust of the Foundation in becoming the single state review agency for the state of Colorado. Dr. Sawyer reviewed the purposes and objectives for which the Foundation was established. He pointed out that while the Foundation has the legislative authority for quality assurance and utilization review in the public sector, no such authority exists for the private sector. Sawyer called on all of the component society officers, members and staff to work with the Foundation, to stay informed and to keep members informed, asking for comments, criticisms and concerns. Sawyer added that the Foundation can only become the single state review agency if it has the complete support of the hospital medical staffs in this state in this undertaking.

R. G. Bowman, Executive Vice President of CMS and CFMC, gave an executive report to the meeting, providing the members with his assessment of physicians' interests in Colorado, as compared to their interests in California, where he has worked in the medical association field for over 22 years. Bowman listed these interests in their order of importance to Colorado physicians:

- Malpractice
- Government regulations
- Blue Cross/Blue Shield reimbursements
- Medicaid
- Physicians' fees
- Patient care
- Cooperative purchasing
- Unions
- Legislation
- Public Health and Safety

Bowman pointed out that all these areas are of concern to the Society officers and staff, as well, offering his own ten-point program for CMS during the first of the 80s:

- Building....but it will take two years, although space is needed now.
- Income....increasing non-dues income as a hedge against inflation.
- Future changes (additions) in CMS staff to carry out the charges of the Board and the House of Delegates.
- Legislation....and CMS involvement in shaping that legislation.
- Legal "reserve" for the Society, anticipating a growth in litigation involving members.
- Closer relationships with allied health organizations and providers.
- Greater flexibility and speed in accomplishing CMS goals (through changes in the By-Laws).
- More effective (and more) communication between members, officers, and staff of CMS.
- More contact with community leaders and development of public support.
- Strengthen the Colorado membership in the American Medical Association.

Bowman pointed out that he couldn't possibly get every member's favorite project or concern on his list, but urged the component societies to talk with him about their views.



Five workshops were held during the day-long meeting, each of these chaired by a component society MD. Each of the five workshops came back with some positive suggestions as to how the Colorado Medical Society could better its services to the components and to the members, and how the components could better use the facilities made available through all of the CMS resources and assets.

The meeting was chaired throughout the day by K. Mason Howard, MD, President-elect of CMS, who added that another such meeting would be held soon after the Annual Session, and that his programs and the programs of his councils and committees would be shaping their programs on those views and suggestions developed in these workshops. Each of the five workshop chairmen, Jim Urban, Adams County-Aurora, Bill Ezell, Northeastern Colorado, Ted Sills, Weld County, Bob Johnson, Larimer County, and Jerry Hansen of El Paso County, reported to the attendees as a whole, providing a number of meaningful suggestions which will be considered and/or carried out by members of the Board of Trustees. Ray Witham and Mason Howard termed the Component Society Officers' Meeting a success, with thanks to all who participated.

### 'ALL THAT SUPPORT'

Component Society members got a stern but friendly (and different) reminder that members of CMS have a lot of support, even though it seems this support wanes frequently. News stories come out espousing views which are contrary to the physicians' view of the practice of medicine. Even though it seems the public support of the doctor is weak, there's always one group which is in back of the doctor.....the Colorado Medical Society Auxiliary.

CMS Auxiliary President, Kathy Thompson of Fort Morgan, Colorado, says there are all kinds of "support devices," but the most effective for the physician can be found in his or her own home: the distaff member of the Auxiliary. This year, thus far, the Auxiliary has conducted a highly effective program of public support and awareness of the physician, and has an even more intense program for the coming year. Working closely with officers and staff members of CMS, the Auxiliary is a viable force in maintaining high public regard for health issues and medical ethics.

(Note: Be sure to see picture pages elsewhere in this issue, and read and complete the "PHYSICIAN FAMILY" survey.)

### PHYSICIAN FAMILY.....'FAMILY AFFAIRS'

A perspective on the emotional, social and psychological impact of being a member of the physician family. This symposium explores the special pressures, unusual demands and unique opportunities that result from having a physician as a spouse, mother or father. Results of an extensive survey of attitudes within the physician family toward marital harmony, sexuality and child-rearing will be discussed. Drawing on this survey and the available literature, an overview of the typical structure and dynamics will be presented. Special attention will be given to areas of potential dysfunction and means of possible prevention and remediation.

The Colorado Medical Society Auxiliary promises an interesting and an important program for the Annual Session (September 23-27, 1980); it is a subject around which every physician's family functions (or dysfunctions). The Auxiliary symposium, entitled "Family Affairs," will be one of involvement for all the attendees, featuring exploration of family problems, role-playing, feeling-expression, and working mental health therapists who will guide the session.



The family role is vitally important today to the physician who is genuinely concerned with the public's health and safety. No, not just his patient's family, but his own family role must be considered. The Auxiliary symposium, is designed to make the physician's spouse more aware of the impact of the profession (professional) on the family. Kathy Thompson, CMS Auxiliary President, says "We hope to bring into the symposium a briefing of the new CMS Committee on Physician's Health and Rehabilitation."

There will be two therapists who will direct the symposium:

Lee Trevithick, Therapist, Larimer County Mental Health Center,  
Special Services Division.

Christine Hearth, Co-therapist, also from Larimer County Mental  
Health Center.

This symposium is important, but that doesn't mean it can't be fun, so try it; you'll like it! Friday, September 26th, 8:30 to 11:30 am. (See the schedule in this edition.)

#### "LETTER FROM THE EDITOR," JUNE, 1980

(Editor's Note: It seems only fair that, in reflection, I go back and add a post-script to the open letter to Dr. Michael Shoo concerning the activities of Colorado Medical Society on behalf of physician support. Better than that, the following is an up-date report filed by Jan Holman, member of the Denver Medical Society Auxiliary and the DMS Public Information Committee, also a contributing writer for COLORADO MEDICINE.)

CMS is taking the initiative in promoting a positive image of physicians by participating in several public media programs, including television, radio and newspaper. These programs are providing medical information to the public.

"MEDICALINE," a monthly, half-hour program on KMGH-TV, Channel 7, Denver, at 5:30 pm, Sundays: Sponsored by DMS and CMS, covers a different topic each month. Host, Dr. Roger Hamstra, and his guests discuss an area of general interest, and viewers then may call in their questions, which are answered on the air. The program has won both local and state awards and has attracted national attention. Subjects covered include such varied topics as First Aid, Holiday Blues, Tick Fever, Hysterectomy, Stroke, Altitude Sickness, Hearing/Speech, Air Pollution, Pediatric Cancer, Reconstructive Surgery, Frostbite and Ulcers. Over the past five years, approximately 30 hours of current, useable medical information have been provided by this outstanding program.

"DENVER NOW," a weekday morning interview program on KWGN-TV, Channel 2, Denver, features hostess Beverly Martinez with interviews of Colorado Medical Society physician members. The program deals with a different subject each week. This program was commenced under the auspices of KWGN and Bob Hahn, the then Public Information Director for CMS and DMS. Since its inception in December, 1978, the program has dealt with 71 subjects, which means that Beverly hosted 71 different guests from CMS, and the public has been provided with approximately 12 hours of discussion of these medical topics.

"HEALTH POWER" was the theme of the health awareness campaign sponsored by the Colorado Medical Society and Auxiliary this spring. Information was sent to newspapers, radio and television stations and many large and small companies and corporations across the state. Governor Richard Lamm, Denver Mayor William McNichols and many other city and county officials proclaimed March, 1980, as "Health Power Month." Colorado Medical Society, on behalf of all the members, distributed some 80,000 pamphlets outlining the seven basic health habits and health tips "your physician wishes you had." These pamphlets have gone to hospitals, clinics, offices, waiting



# The endurance athlete's heart:

## *"Abnormal" Is Normal*

**Richard M. Burton, MD, Colorado Springs**

Runners, and other endurance athletes, in quest of fitness or even a world record, are faced with remarkable body changes which are signs of training when looked at by the knowledgeable eye, yet may mimic "abnormal" when the long-distance component is ignored.

An overview of the endurance trained heart is presented, in order that the examiner may understand what is abnormal for the sedentary individual may be normal and adaptive in the athlete.

Cardiac alterations are perhaps the most common of adaptations to occur in the athlete trained in endurance sports, and these alterations are occasionally worrisome to the athlete or the untrained observer.

### *Cardiac Enlargement*

Twenty to thirty per cent of endurance athletes may show X-ray findings of cardiomegally, probably representing that percentage of hearts photographed in diastole. In addition, 20% of the athletes may show echocardiographic signs of LVH. However, these athletes showing increased wall thickness and diastolic volumes will also show decreased systolic volumes, greater stroke volumes, more rapid muscle fiber shortening and normal coronary blood flow per unit-mass of tissue, indicating superior heart function when compared to the "normal" sedentary individual.

The echocardiogram, at present, appears to be the best means of evaluating the athlete's heart when underlying pathology is to be ruled out.

### *Auscultatory Changes*

A third heart sound is almost a universal finding in well trained endurance athletes, with some 50-75% also exhibiting a fourth sound. Also, 50-75% of the group may exhibit an innocent systolic flow murmur, with occasional diastolic venous hums. Again, an echocardiogram with normal mitral valve evaluation ensures that these are merely adaptive changes.

### *ECG Changes*

Voltage criteria for LVH is extremely common, yet there should be no cause found for such changes as far as hypertension, aortic stenosis or asymmetric septal hypertrophy. ST-T changes of pathologic LVH are not present in the athlete's tracing. Left axis deviation seen in pathologic conditions should not be present in the endurance trained individual who may in fact

have a slight rightward axis. Early repolarization ST changes may occur in the athlete's ECG, as well as peaked or biphasic T-waves and Right Bundle Branch Block.

Rhythm alterations normal to the athlete include almost always a sinus bradycardia. Occasionally junctional bradycardia and various sinus arrhythmias can occur. First degree block, characterized by a long P-R interval, is felt to be a normal variant also.

Ventricular ectopic beats which occur at rest, often after a hard work-out, and disappear with activity, are common. Keeping these changes in mind, which are normal for the endurance athlete's heart, the examiner can do a great service to the cyclist, runner, cross-country skier or swimmer by not labeling him as "abnormal" and inducing a cardiac-cripple syndrome into an actually extremely fit individual. When doubt exists, an echocardiogram can be of great benefit, and may save much anguish for the athlete and his family. Remember, for the endurance athlete's heart, "abnormal" may be normal. ●

### **Gelman Named to Head Allergists**

Lloyd D. Gelman, MD, Boulder allergist, has been named president of the Colorado Allergy Society for a two year term, succeeding Dr. Alan Wanderer. Other new officers are Dr. Harold Nelson, vice president, and Dr. Constantine Falliers, secretary-treasurer.

### **Conger Named to MacArthur Foundation Staff**

John J. Conger, PhD, former vice president for medical affairs, medical school dean, and director of adolescent psychiatry at the University of Colorado, Denver, has been named vice president and director of health programs at the MacArthur Foundation of Northbrook, Illinois.

Conger joined the University of Colorado faculty in 1953, coming from Indiana University. He is a 1943 magna cum laude graduate of Amherst College, and received a doctorate in psychology from Yale University in 1949.

Conger was a fellow of the Center for Advanced Study in the Behavioral Sciences, Stanford, California in 1970 and 1971, and in 1978 was a visiting scholar at the Institute of Human Development, University of California at Berkeley.

The MacArthur Foundation is an independent, private foundation created for charitable and public service purposes by the late insurance executive, John D. MacArthur, and his wife, Catherine T. MacArthur.

## Legislative Seminar A Success

*T'was Memorial Day weekend  
Concentration was hard  
Physicians and senators  
Lowered their guard.  
Tempers flared, some who glared  
Found their hostilities bared.  
Sharing thoughts and notions  
Prevents the chaos of excess emotions.*

Thirty-four legislators and forty physicians plus a liberal sprinkling of spouses, friends, children, and CMS staff spent the weekend of May 23-25 in Vail. As such weekends go, the initial interfacing was somewhat stiff; but an introductory cocktail party, followed by informal dinner groups, and in some cases disco dancing, helped break down the barriers.

On Saturday, Dr. William M. Robinson key-noted the meeting with his speech entitled, "Are We Spending Too Much on Health Care?." Three different panels made up of both physicians and legislators reacted to that in a variety of ways, and if nothing else, the complexity of health care cost containment became evident. Lunch featured a speech on "You Have A Duty To Stay Healthy," followed by a demonstration for those interested in biofeedback equipment and stress management technics.

The gods blew hard at us Saturday afternoon, and tennis and golf were difficult but possible if one didn't mind an occasional crashing lodgepole pine. The day ended with a lovely dinner, an original rendition of songs from *HMS Pinafore* with words by Senator Hugh Fowler and Dr. Frank Traylor, and more disco dancing for the brave. The video tape produced by CMS's own Bill Pierson during two of the panel discussions was replayed on TV at 11 that evening. It was a fun twist for the panelists to see themselves as others see them.

After a big Sunday breakfast, Dr. Jack Warren found himself moderating the wrap-up session which featured the Saturday panelists on stage and the legislators in a VIP section. Tempers flared several times over the subjects of HMO's and reimbursement to physicians. The Voluntary Effort to contain costs, the failure of physicians to take active roles in political campaigns, rationing of health care were all discussed. Somewhere along the way "cost containment" was tossed out and replaced by "cost effectiveness."

The evaluation sheets gave the seminar good

grades; and if there was a standard complaint, it was that there should have been more small-group discussion and one-on-one contact. Valuable friendships were formed - friendships that should be of great assistance in legislative sessions to come. That, of course, was the number one reason for hosting the weekend - let's be sure those relationships remain intact!

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## new members

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**Denver Medical Society:** Shane Maa, Gary M. Miller, Elizabeth Ann Saria, Samuel E. Alexander, Jr., Russell Buesing, Larry E. De Vold, Pamela Gallagher, James E. Geddes, Victor D. Lopez, Alan R. Hopeman, Clyde M. Burnham, Eugene S. Farley, Jr., Raymond E. Garrett, Linda A. Burnham, Stephen R. Hoffenberg, Jimmie R. Stone, Christopher S. Fletcher, Ronald D. Franks.

**Mesa County Medical Society:** Richard A. Janson, Frank J. Metzger.

**Arapahoe County Medical Society:** William W. Mears, Thomas T. McCloskey, William G. Stanley.

**Boulder County Medical Society:** Victor J. Thompson, Mark Daniel Haimes, Harlan D. Hibbard.

**Clear Creek Valley Medical Society:** Stephen L. Axelrod, Russel Broholm, John J. Hopper, Jr., Paul K. Lewis, Jr.

**Intermountain Medical Society:** Ronald Jondry, Tom Nevison.

**La Plata County Medical Society:** Henry M. Heller.

**Adams County-Aurora Medical Society:** John W. Kolmer.

**Las Animas County Medical Society:** Andro P. Gagne, Oscar M. Wilbur.

**Pueblo County Medical Society:** Joseph Guerin, Jr., Alexander Wm. Williams, Jr., William D. Hinsberg, Jr.

**Huerfano County Medical Society:** Leonce G. Evans.

**Weld County Medical Society:** John R. Steinbaugh.

**UCHSC Student:** Thomas Neil Chisholm.



# The real cancer risks in Colorado

John W. Berg, MD, Denver, Colorado

*Since these figures are ten years old, they are out of date in many ways. Still they do call attention to special cancer problems of importance to Colorado. They are superior to the other available figures that are currently being used in discussions and planning and it will probably be 3 or 4 years before a full set of equally reliable, multi-year data on incidence can be available from the Colorado Department of Health's new cancer incidence collection program.*

## Introduction

In 1975, data on Colorado cancer incidence were published as part of the formal report of the Third National Cancer Survey (TNCS).<sup>1</sup> The other survey areas were Pittsburgh, Detroit, Atlanta, Birmingham, Minneapolis-St. Paul, Dallas-Fort Worth, San Francisco-Oakland, and Iowa. Rates were provided for the years 1969-1971 for "all races", "whites", and "blacks". Colorado and Iowa showed the lowest cancer rates. This was because only those two areas contained substantial numbers of rural residents, and rural residents traditionally have shown lower risks than urban residents for many types of cancer, lung cancer, breast cancer and bowel cancer in particular. Moreover in Colorado the word "white" had a different meaning than it did in any other area: it included the Hispanics who, by maintaining much of their own ways, also maintained, as we show here, cancer rates lower and quite different by type than the remainder of Colorado residents.

In order to establish priorities for the Colorado Regional Cancer Center's efforts in all aspects of cancer control and for our own unit's research activities, we re-analyzed the TNCS data for Colorado to eliminate these biases. The rates that we want to compare with other urban cancer rates are those for urban, non-Hispanic Colorado residents. Equally important we wanted to look at the contrasts among the various Colorado subpopulations: metropolitan city versus other residents, and Hispanics versus other urban and non-urban whites.

## Materials and Methods

The basic data tape corresponded to that used to produce the final TNCS summaries and was kindly furnished by the National Cancer Institute. Although finer divisions are possible and may have their purposes, we chose to contrast the two-thirds of Colorado residents who live within "Standard Metropolitan Statistical Areas" (SMSA's) with all residents living outside the SMSA's taken together. Had the non-SMSA residents shown more high cancer rates, there would have been more reason to determine if these high rates were ascribed to residents of medium-size cities, small towns, or to truly rural residents.

Hispanos were identified by matching surnames on a previous tape prepared for local use by Survey staff against the Census list used to code 1970 case material. The same rules for including names with prefixes or suffixes not on the master list were followed to the best of my ability. The coding could not exactly match the census denominators since the census began with information on language and coded most people as Hispanics on the basis of Spanish language use. However, the results agree so closely with study of other Hispanic groups that we believe the errors must be very small.

To compare Colorado rates with those of other areas without recalculating all the other rates, it was necessary to use Colorado rates standardized to the 1950 U.S. population by direct age adjustment. Because the Hispanic populations are much smaller, direct age adjustment is not a preferred technic and instead the *observed* number of cancer cases in the Hispanic subgroups was compared with the number *expected* if at each age the group had shown the cancer rate of non-Hispanos in the SMSA's. A few age-specific comparisons were made where the number of cases permitted, and will be commented upon.

Total rates, rates for all whites, and rates for blacks are available in the TNCS report. Blacks

in Colorado were almost all SMSA residents and their rates have been taken directly from the TNCS report and compared with rates from other areas and with the Colorado SMSA rates. Information is presented only for the more common cancer sites and for sites of particular epidemiologic interest. In general, sites not described showed no major incidence differences between groups or between Colorado and the other TNCS areas. More detailed information on specific problems will be furnished on request if we have it or can generate it from our data. In particular we have calculated the cancer rates for Anglos in each county. (The rates for other ethnic groups were subject to too much error to look at in this detail.) Fuller tables on statewide rates will be included with the reprints.

## Results

For general orientation Table 1 lists some of the actual counts for new cancer cases. In the 3 years a total of 16,128 new cancers (excluding non-melanoma skin cancers) were diagnosed. The primary site was never determined for 498 of these. As elsewhere in the U.S., four sites

provide half the total cancers: breast, large bowel, lung, and prostate. Control of these four cancer types must remain the priority of any cancer program.

### A. Cancer in non-Hispanic white residents

Table 1 also presents incidence rates for the major types of cancer in non-Spanish whites in the Colorado SMSA's and compares these with the composite TNCS rates. Where Colorado rates are high, the rank among the 9 TNCS areas also is given. (The 7 SMSA's in Iowa were considered as one area for this comparison).

Overall, the Colorado rates were 4 per cent below the average for the TNCS. Men had 3 particularly large deviations from the national rates. Lung cancer was 19 per cent below the national average, well below the rates in any other metropolitan population. At the same time, the incidence of prostatic cancer was 28 per cent above the TNCS and bladder cancer 21 per cent higher, putting the Colorado men at the highest risks reported in the survey. For prostatic cancer, the rate is higher than any rate reported for whites in the latest compendium of

TABLE 1  
Cancer Cases in Colorado with Comparison to the U.S. Average 1969-1971

Average Case Count per year 1970 (1)		RATES IN COLORADO URBAN NON-SPANISH WHITES					
		MEN			WOMEN		
		Rate (2)	Comparison (3)	Rank (4)	Rate (2)	Comparison (3)	Rank (4)
Total	5376	289.2	-4		24.1	-4	
Breast	872	0.5	-30		75.2	+4	3
Bowel	713	37.2	-15		30.7	-12	
Lung	593	52.3	-19		11.0	-19	
Prostate	574	58.6	+28	1	-		
Bladder	276	24.5	+21	1	5.4	+2	
Uterus (5)	213	-			20.6	-7	
Leukemia	193	9.9	-13		7.6	+12	3
Pancreas	180	10.9	+4		6.3	+2	
Lymphoma	172	10.1	-11		7.0	-9	

(1) All Racial and Ethnic groups. 1969-1971 counts divided by 3.

(2) Per 100,00 population, age adjusted to the U.S. 1950 population.

(3) Percentage above or below the overall Third National Cancer Survey rate (ref.1)

(4) Rank among the 9 metropolitan populations studied.

(5) Excluding cervix. Most are endometrial carcinomas.



world wide incidence rates. Prostatic cancer in fact was more common than lung cancer in terms of age-standardized rates.

Colorado Anglo men showed rates more than 10 per cent below the national TNCS average for oral and pharyngeal cancers, gastric cancer, rectal cancer, lymphomas and leukemias. They had an above average incidence of thyroid cancer (plus 32 per cent, 3rd among 9 metropolitan populations), myeloma (only plus 12 per cent but ranking 2nd), and melanoma (plus 28 per cent, ranking 3rd).

Colorado women ranked first in the TNCS only for one site, cancer of the thyroid. They had 33 per cent more thyroid cancer than the TNCS average, making it their 8th most common cancer. Their cancer pattern followed that of the men with low rates for lung cancer, gastric cancer and rectal cancer and lymphomas though not for bladder cancer or leukemias. In fact their leukemia rate though only 12 per cent above the TNCS average was third highest among the 9 regions. They had relatively low rates for cervical cancer and renal cancer and higher than average rates for melanoma.

#### B. Metropolitan vs. Non-metropolitan incidence

Iowa data from 1950 showed marked differences between urban and rural cancer rates with cigarette cancers (lung, larynx, bladder, pancreas and oro-pharyngeal-esophageal) as well as the cancers of affluent diet (colon and breast) being importantly more common in cities. While there were still differences between metropolitan area residents and others in 1970 in Iowa, the amounts of the differences were much less. In this respect Colorado non-metro rates looked more like 1950 than 1970 non-metro Iowa. Colorado non-metro women showed the kind of large deficits of breast and colon cancer that had been characteristic of Iowa in the earlier survey. Since such rural-urban differences are felt to offer major clues as to etiology, opportunities for study exist here that have all but disappeared in Iowa.

Higher rates in non-metro areas that probably are real existed for lip cancer, rectal cancer (slight but reflecting the past when cancer in the lower rectum was a rural disease), lymphomas (small but consistent excesses in both sexes), and leukemia in men, a disease with higher risk in farmers in Iowa.

#### C. Cancer in Hispanic - Americans

In general cancers were reported in these people substantially less often than in other Colorado whites (Table 2). The total overall relative rate in men of 58 per cent compared to Anglo men is identified with the New Mexico (3) rate. The Colorado rate for women of 66 per cent is below the New Mexico relative rate of 77 per cent. In general our hispanic/non-hispanic ratios for specific cancers were very like the New Mexico and the 2 sets of Los Angeles (4) relative rates. Spanish-Americans can be expected to have incidence rates higher than other whites for biliary cancer, stomach cancer, cervix cancer, penile cancer, and possibly kidney cancer. The relative risks for this last cancer in the other series were lower than we found: .75, 1.10, and .60 for men, .84, 1.11, and 1.04 for women. Risks more or less equal to Anglo risks were found in Colorado for ovarian cancer (though the L.A. rates were .55 and .67), leukemia, and pancreatic cancer. Otherwise the age-adjusted risks for cancer in the Spanish are half or less what they are for the Anglos (2/3 for prostatic cancer). Within these low rates a small metro/non-metro gradient is seen for male lung cancer, breast cancer, and prostatic cancer among the more common cancers.

TABLE 2

Relative Risks for Cancers in Colorado Hispanics Compared to Non-Hispanic Whites (Comparison Group rates= 100% Urban and Rural Values Averaged.)

	MEN	WOMEN
Biliary Tract	298%	399%
Stomach	280%	148%
Cervix	-	158%
Kidney	126%	150%
Uterus	-	26%
Bladder	38%	15%
Lung	28%	68%
Lymphomas	43%	43%
Large Bowel	42%	45%
Breast	-	48%
Prostate	66%	-
All Cancers	58%	66%

When differences in cancer risks are due to cultural factors, this often shows up in age-specific comparisons. For instance when Japanese came to the United States, they rapidly increased their bowel cancer risk and gradually lost their stomach cancer risk. The differences between Japanese migrants and other Americans are greatest among the oldest age groups, partly because the older migrants may have left Japan later in life, partly because they maintained more of their traditional

Japanese life style in Hawaii or California than did the Japanese who migrated earlier in life. Similarly in the TNCS, older blacks had bowel cancer rates well below those in the white population but blacks under 55 years of age had more bowel cancer than whites of the same age. Presumably the younger group had adopted the white life style and diet more completely. In the present study it was expected that younger Hispanics would have cancer rates more like those of the other whites. This was *not* the case. The young and the old both showed the same kind of differences. If any group was different it was the middle aged group (55-64). But it is hard to make sense of the differences: sometimes their rates were more like the other whites but equally often they were even more different. The one tentative conclusion one might draw from looking at the age-specific rates is that heredity may play more of a part in the Hispano non-Hispano differences than hitherto expected. Otherwise there should have been some coming together of the incidence rates in younger whites.

#### D. Cancer Rates in Colorado Blacks

Table 3 presents some incidence rates for Colorado blacks. In general the rates arise out of both the characteristics of the general TNCS black rates and the special characteristics of Colorado urban rates. The excess of prostate cancer in both groups made the Colorado black rates by far the highest ever reported in any population. Lung cancer rates are as high as the average for blacks who did not share the lower rate of other Colorado metro men. These two sites are largely responsible for the high total rates for black males. By contrast the total incidence for black women is almost as low as for white SMSA residents in Colorado. It is worth noting that bladder cancer in men and thyroid cancer in women about equal the high rates for Colorado metro whites although black rates for these cancers generally are fairly low. As seen for blacks generally, stomach cancer, myeloma, esophageal cancer, and cervical cancer all are more common in Colorado blacks than whites.

#### Comment

Although in Colorado as elsewhere in the country, bowel, breast, lung and prostatic cancer made up half of all cancers of known

TABLE 3  
Relative Risks (comparison group = 100%)  
for Cancers in Colorado Blacks Compared with Blacks  
in Other Areas and Colorado Urban Non-Hispanic Whites

	Other Blacks	Colo. Anglos	Other Blacks	Colo. Anglos
Prostate	148%	197%	-	-
Lung	103%	165%	93%	110%
Cervix	-	-	81%	243%
Bladder	198%	87%	39%	26%
Stomach	69%	153%	77%	147%
Myeloma	212%	403%	83%	209%
Esophagus	68%	292%	69%	312%
Thyroid	282%	107%	221%	101%
Breast	-	-	118%	89%
Bowel	86%	87%	110%	116%
All Cancers	111%	136%	100%	101%

origin, Colorado differed in its lower lung cancer rates and higher prostatic cancer rate, especially among metropolitan residents. Unfortunately, it appears as if the bad part of this picture has been maintained but the good part lost. In the absence of incidence rates for the mid-1970's, we estimated the trends in major cancers from relative frequency changes. Bowel cancer was used as a standard, since its incidence has remained quite stable in most areas of the U.S. for many years. By 1976 it appeared that lung cancer in Colorado was as common as it was elsewhere in the U.S.: rates had risen 45 per cent in men and 62 per cent in women over the TNCS rates. Breast cancer was up 20 per cent. Some of this rise might have been due to more silent cancers being found by mammography but the trend is being seen even in areas of the U.S. where mammography use is not common. Prostatic cancer was also increased by 20 per cent, insuring that Colorado would maintain its lead in incidence. Leukemia was up 50 per cent in men and 25 per cent in women. Endometrial cancer rose rapidly in incidence until 1975 when it was almost twice as common as in 1970 and then decreased. This trend accords with national trends and the common use of estrogen for menopausal symptoms until the early reports of cancer risk led to decreases in frequency and amount of drug prescribed. Unfortunately, the withdrawal of funds for support of the epidemiology program has precluded us from updating these results or studying the changes of interest. Our activities now are



limited to a grant-supported study of rare cancers but the Colorado Department of Health has reinstituted incidence studies as mentioned above so that within a reasonable time current information on Colorado cancers will be available.

### Summary

When Colorado cancer rates for 1969-1971 are looked at by ethnic group and place of residence, patterns appear that were not visible in the overall figures. Black men had very high rates, especially for prostatic and lung cancer. Hispanos generally had very low rates despite

high rates for gastric, biliary, and cervical cancer. Urban non-Hispanic white men had the highest rates reported in whites for prostatic and bladder cancer but rates as low as rural residents for lung cancer. Urban white non-Hispanic women had high rates for thyroid cancer. These special risks plus the expected commonness of bowel and breast cancer establish the priorities for cancer control programs and for our unit's research efforts. ●

Dr. Berg is Associate Director for Epidemiology and Statistics, Colorado Regional Cancer Center. Supported by Grant No. CA 17060-03 awarded by the National Cancer Institute. The original data were collected by the State Cancer Registry, Colorado Dept. of Health under an NCI contract and were edited into final form by the Registry and NCI staff. Address for reprints: Department of Pathology, University of Colorado, 4200 E. 9th Avenue, Denver, Colorado 80262.

### REFERENCES

- <sup>1</sup> Cutler, S.J. and Young, J.L., Jr., eds.: Third National Cancer Survey: Incidence Data. *National Cancer Institute Monograph 41*, U.S. Dept. H.E.W., Bethesda 1975.
- <sup>2</sup> Haenszel, W., Marcus, S.C., and Zimmerman, E.G.: Cancer Morbidity in Urban and Rural Iowa. *Public Health Monograph 37*, U.S. Dept. H.E.W., Washington 1956.
- <sup>3</sup> New Mexico Tumor Registry: *Cancer in New Mexico 1969-1972*. Albuquerque, New Mexico Tumor Registry, 1975.
- <sup>4</sup> Menck, H.R., Henderson, B.E., Pike, M.C., Mack, T., Martin, S.P., Sooho, J.: Cancer Incidence in the Mexican-American. *J Natl Cancer Inst 55*, 531-536, 1975.
- <sup>5</sup> Bailar, J.C. and Ederer, F.: Significance factors for the ratio of a Poisson variable to its expectation. *Biometrics 20*: 639-643, 1964.

### Sharp Named to Arthritis Center

John Sharp, MD, nationally known clinician, teacher, and researcher in the field of arthritis and rheumatic disease, has been named to be Director of the Joe and Betty Alpert Arthritis Treatment Center.

In addition, Dr. Sharp will direct a clinical arthritis research program.

Dr. Sharp received his MD from Columbia University, New York; he interned at Presbyterian Hospital, New York, and completed his residency at Mary Hitchcock Hospital, Hanover, New Hampshire, and served a clinical fellowship at Massachusetts General Hospital in Boston.

From October 1976 until recently he served as Chief of Medical Services for the Veterans' Administration Hospital at Danville, Illinois, and as Professor of Medicine at the University of Illinois, Champaign-Urbana.

### McGlone Heads Geriatricians

Frank B. McGlone, MD, has been named president-elect of the American Geriatrics Society. Dr. McGlone is executive director of the Medical Care and Research Foundation in Denver, and recently was named to the new position.

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**new  
officers**

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### INTERMOUNTAIN MEDICAL SOCIETY

#### PRESIDENT

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Vail, Colorado 81657

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## Physician Placement/Recruitment

What's happening to physician placement/recruitment efforts in Colorado? That's a question that is difficult to answer, for a number of reasons: 1) those newly-graduated family practice physicians may choose to go to an area for a time, but soon change their mind about specialty practice or about the area in which they commenced their practice, and move; 2) those who set up practice in some rural areas are finding that the job of acceptance in an area is largely a question of "turf," (to use a big-city term) and whether the new physician is allowed to enter a practice area of some established physician; 3) many of the new physicians are finding that their interests are more in earnings than services needed or services rendered, and are opting for specialty practice which they feel will produce higher income, and it does take money to run a practice today, no matter where you are.

So what is the case for physician placement in rural areas of Colorado (or elsewhere)? Colorado Medical Society is doing what it can to aid in physician recruitment and/or placement. CMS computer files now contain 178 entries for physicians seeking practice opportunities in Colorado, and 25 entries for positions available. At least 75 per cent of the inquiries for physicians are out-of-state practitioners, and approximately 60 per cent of those individuals will not be available until 1981 and 1982. Requests for locum tenens are increasing, as well as requests for part-time openings. The CMS Division of Socio-Economics has placed two full-time physicians in the Denver area since May 1, 1980, and one part-time, also in Denver. The rural needs remain a key emphasis, and the goal of the CMS staff is to place at least one rural practitioner in Colorado by September 1, 1980.

The Governor's Office and Rural Health are working, full-time, to help satisfy the medical and health-care delivery needs of all Colorado. Most recently, a non-profit corporation has been formed under the name of "The Colorado Rural Health Recruitment and Manpower Consortium." In its early organizational efforts, the consortium has been in contact with chambers of commerce, business and community leaders, township, city and county government officials, assessing the needs of these people and the areas. They are also soliciting further support and involvement by the various business, government, social and public leaders in the consortium efforts. We'll see more in the way of activity by the recruitment consortium, now that it is a corporate entity and qualified to accept funds for operation. If anyone would like more information about the consortium for recruitment and placement, contact Board member Joyce Kriewald in the Governor's Office of Rural Health at the state

Capitol.

In Colorado, since the first class of family practice physicians was graduated (1975), there have been a total of 105 FPs go into practice. Of this number, 63 per cent are still in Colorado, 28 per cent are practicing in rural Colorado and 22 per cent are practicing in rural areas of other states. Of the total (105), 49 per cent are practicing in rural communities, and of those who remained in Colorado, 44 per cent are practicing in rural areas or communities. Of those who are completing residency training this year (32), 10 are moving out to rural areas of Colorado, and 10 others did not know (in late May) what they would do. In Colorado there are 2 of these doctors planning on locating in Colbran, 2 in Lajara, 2 in Mancos, and one in Sterling. Interestingly enough, the doctor in Sterling is Bob Marlow, who is a member of the Board of Directors of the Colorado Academy of Family Practice.

Since October of 1979 the activities and plans of two Colorado FPs have been followed and rather well publicized by a variety of people and news agencies. Why? Because these two, who finished their residency in June, announced plans late last year to set up practice in the town of Mancos, Colorado. Their plan was announced, in fact, in the Mancos Times-Tribune, on the front page of the October 4, 1979, edition: "DOCTORS PLANNING PRACTICE IN MANCOS." And, the pair have been making news ever since. COLORADO MEDICINE looked into the situation to see if this was a story of particular interest, or if it was typical of the state of Colorado's rural medicine.

The Mancos Times-Tribune story in October said "Two young doctors are negotiating with the Mancos Valley Development Company and are wishing to move to Mancos." The story went on to say that the two doctors, Kent R. Aiken and Richard G. Marek, Jr., were to complete their three years of residency in family practice in June of 1980 and would become state board certified by July and wanted to be in Mancos by that month. It was further reported that "This is the third visit they have made to Mancos and have committed themselves to move here. The men and their wives have fallen in love with the area and are desiring to go into a lease-purchase contract with the development company on the Mancos Clinic."

A person has to read into the story very little to find that this is NOT the typical rural doctoring story. First of all, the town of Mancos, located in the southwestern corner of Colorado in Montezuma County, had a clinic. The clinic was the product of an earlier town development project which did not pan out. Secondly, two young doctors had it in their minds to settle in just such an area, came looking



and found what they wanted.

Just what are the factors which influence a physician to set up or assume a practice in a rural area? They are many . . . but high on the list has to be the attitude of the doctor about rural community life, the remoteness of an area from urban centers, determination to make the best of a situation despite having to reshape his personal life to do so. Looking back into the attitudes of the two doctors who are going to Mancos, Dr. Richard Marek was born in Albuquerque, New Mexico, and spent a majority of his childhood in Carlsbad, N.M. His undergraduate studies were completed at the United States Air Force Academy and the University of New Mexico, where he also attended medical school. Dr. Marek elected to do his residency in Pueblo primarily, he says, because of the community size. Marek said "I knew I wanted to eventually end up in a small town, and Pueblo provided a perfect intermediate step between a medical school practice and a true rural practice." Marek added: "We, my wife and I, have chosen Mancos as a practice site for a variety of nonspecific reasons. We love the area. The people are self reliant, friendly, and in need of local medical care. Mancos is reasonably close to our respective homes, and very close to skiing, hiking, etc." Dr. Kent Aiken, on the other hand, was born in Uniontown, Pennsylvania, and he grew up in Pittsburgh. He graduated from Hahnemann Medical College in Philadelphia and then moved west. Dr. Aiken adds, "I did not feel comfortable in the impersonal, crowded, fast-paced cities in the east, and have found the open, relatively unspoiled countryside and the friendly, caring attitude of the people here much more to my liking. My wife shares these sentiments, which is of course an important factor in our decision to remain in Colorado. We have chosen to move to Mancos because there seems to be a real need for physicians there, the people have demonstrated a genuine interest in us, and because it provides a rural, agricultural setting in which my wife and I can pursue the many outdoor activities we enjoy."

In Mancos, in January, 1980, a shareholder's meeting of the Mancos Valley Development Company attracted over 1,200 stockholders, either in person or by proxy, and the body gave overwhelming approval of the proposed lease on the Mancos Medical Clinic to Drs. Richard Marek and Kent Aiken. The Directors of the company encouraged residents to invest in the company. Stock was for sale at \$10 per share and \$25,000 was needed to clear up back indebtedness, which included back

interest on loans and back taxes on the property. As the Mancos Times-Tribune story said, "The community has had a struggle making this dream come true, however, it appears at this time that help is definitely on the way as Drs. Marek and Aiken are eager to move to our rural community. They have visited on several occasions with their wives who are just as excited and eager to move here as their husbands. They are aware of the needs, and of the problems of the area and are still wanting to make their homes here, according to those who have worked closely with them over the past year."

The Mancos Clinic was built at a cost of some \$110,000 and is about five years old. It was first occupied by a young Canadian doctor, Harold Bryan, but Mancos residents don't feel that Dr. Bryan or his wife and two children were happy in the area. The Bryans gave up the clinic practice in less than a year. Next came a doctor from Dolores who operated the clinic for two years. The practice and the lease were given up for personal reasons, not having to do with the practice. Then followed a period in which the clinic was opened only on an emergency basis, and staffed by a physician's assistant. The clinic has been closed for the past year.

At last report, both new physicians have taken up residence in Mancos. They will have taken their state board certification, and now plan on having the clinic open on a regular basis by the first week in August. Recently, the Mancos chapter of the Business and Professional Women hosted a reception for the doctors and their wives. The reception was very well attended, and everyone in the Mancos area is looking forward to the new residents; they feel that the new families will fit in quite easily. There were concerns about income requirements of two doctors, however it is believed that the doctors have their plans well made: The two physicians will have a schedule of days on call, and both plan on extra work in area emergency facilities to help offset the costly days of establishing themselves. Dr. Aiken has been working recently with Dr. Gerald Howe in the Cortez hospital, finishing up his residency training during June.

The town of Mancos, according to the latest census, had a population of 900, but the clinic will serve a rural area of over 2,300 residents. The clinic is well equipped, and is well situated on the highway bypass, but is quite accessible and has ample parking. The clinic is just 17 miles from the Cortez hospital.

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# library gleanings

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The ongoing problem of how to put the elements of readability - cadence, balance and phrasing, and vigor - into scientific writing has been addressed by a recently acquired volume in the Denver Medical Society Library - "Dx + Rx - A physician's Guide to Medical Writing" by John H. Dirckx, MD.

Dr. Dirckx delivers a strong case for considered and clear language and those matters which go together to constitute style. The volume is heartily recommended by the editors of *Colorado Medicine* for its contributions to clarity and precision of thought.

*Dx + Rx, A Physician's Guide to Medical Writing*, John H. Dirckx, MD, G.K. Hall and Co., Medical Publications Division, Boston, Massachusetts, \$12.95.

In the May *Colorado Medicine*, details of the Central Colorado Library Systems Courier service were given. That issue indicated the June issue would provide information for physicians not served by the Central Colorado system.

To achieve access to the resources of the Denver Medical Society, physicians may use a free in-WATS line (1-800-332-4150) which reaches the Library. Requests for needed materials can then be made to the librarian who will do one of several things.

If the content of a particular article or textbook must be known immediately, key sections can be read over the phone.

If there is more time, a photocopy will be made and mailed within twenty-four hours of receiving the request.

Additionally, a MEDLINE search can be requested by phone. The print-out of the search (list of references) can either be mailed to the physician, or the librarian can place a phone call to the physician, and read to him the titles of the articles identified in the search.

In memory of the late Dr. Harry Whitaker, who died January 5, 1979 at the age of 96, a subscription to *The American Journal of Otolaryngology* has been made to the Denver Medical Society Library by the Colorado Otolaryngologic Maxillofacial Society.

The attention of those who practice running and jogging for exercise and of those who may be re-

quired to deal medically with injuries stemming from such activity is directed to a current symposium carried in the March/April 1980 issue of *The American Journal of Sports Medicine*, official publication of the American Orthopaedic Society for Sports Medicine.

This symposium carries articles on *Runner's Injuries* by William G. Clancy, Jr., MD; *Environmental Factors in Running* by William B. Smith, MD, which covers altitude problems in running; *Running Footwear* by David Drez, MD, and the problem of *Chronic Leg Pain* by Don E. Detmer, MD.

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## book corner

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### PHARMACOLOGY

**Merck Index/An Encyclopedia of Chemicals and Drugs.** 9th ed. Rahway, N.J., Merck and Company, 1976. 1952 p. \$18.00.

### PATHOLOGY

**Cancer Treatment:** Charles M. Haskeli, ed. Philadelphia, Saunders, 1980. 1133 p.

### MEDICAL PROFESSION

**Abbreviations in Medicine:** Edwin B. Steen. 4th ed. London, Balliere Tindall, 1978. 136 p. \$8.95.

**Conference on Credentialing of Health Manpower and The Public Interest:** Anne R. Warner. New York, National Health Council, 1978. 69 p.

**Health Care Issues: Physician and Public Attitudes:** American Medical Association. Center for Health Services Research and Development. Chicago, A.M.A., 1979. 98 p.

**Health Careers Guidebook:** U.S. Department of Labor. 4th ed. Washington, D.C., G.P.O., 1979. 221 p.

**The Impaired Physician:** American Medical Association. Chicago, A.M.A., 1978. 96 p.

**Medical Technology:** National Center for Health Services Research. Hyattsville, Md., Dept. H.E.W., 1979. 120 p.

**Medical Technology. The Culprit Behind Health Care Costs?** Proceedings of 1977 Sun Valley Forum on National Health. Stuart H. Altman, ed. Hyattsville, Md., U.S. Dept. of H.E.W., 1977. 306 p.

**Modern Legal Medicine, Psychiatry and Forensic Science:** William T. Curran and others. Philadelphia, Davis, 1980. 1310 p.

**National Health Practitioner Program Profile 1979-80:** Association of Physician Assistant Programs. 4th ed. Arlington, Va., 1978. 138 p. \$7.50.

**1978 Colorado Physicians (D.O.):** Colorado Department of Health. Denver, Colorado Department of Health, 1980. 18 p. Gift.

**Sharing Health Care Costs:** Brian Abel-Smith. U.S. Department H.E.W., 1980.

**New Directions in Public Health Care:** Cotton M. Lindsay and others, ed. 3rd ed. San Francisco, California, 1980. 290 p.



## **PUBLIC HEALTH**

**Colorado Vital Statistics 1978:** Colorado Department of Health. Denver, Colorado, Colorado Department of Health, 1979. 36 p. Gift.

**Disease Prevention and Health Promotion, Report of the Departmental Task Force on Prevention.** Washington, D.C., Public Health Service, 1979. 203 p.

**Health of the Disadvantaged: Chart Book:** Tony Hausner. Hyattsville, Md., U.S. Department of Health, Education, and Welfare, 1977. 98 p.

**Preventing Disease/Promoting Health: Objectives for the Nation:** U.S. Department of Health, Education and Welfare. Washington, D.C., Department of H.E.W., 1979. 118 p.

## **PRACTICE OF MEDICINE**

**Holistic Medicine:** Kenneth R. Pelletier. New York, Delacorte Press, 1979. 330 p. \$10.00.

**Fever:** James M. Lipton, ed. New York, Raven Press, 1980. 263 p. \$27.50.

## **METABOLIC DISEASES**

**Metabolic Control and Disease:** Philip K. Bondy and Leon E. Rosenberg. 8th ed. Philadelphia, Saunders, 1980. 1870 p. \$75.00.

## **MUSCULOSKELETAL SYSTEM**

**Head Injury:** Louis Bakay and Franz E. Glasauer. Boston, Little, Brown, 1980. 445 p.

**Metabolic, Degenerative, and Inflammatory Diseases of Bones and Joints:** Henry L. Jaffe. Philadelphia, Lea and Febiger, 1972. 1101 p. Gift.

**Total Hip Replacement:** Malcolm Jayson, ed. Philadelphia, Lippincott, 1972. 152 p. Gift.

**The Orthopaedic Traction Manual:** Andrew F. Brooker. Baltimore, Williams and Wilkins, 1980. 110 p.

**Tumors of the Head and Neck:** John G. Batsakis. 2nd ed. Baltimore, Williams and Wilkins, 1979. 573 p. \$46.00.

## **CARDIOVASCULAR SYSTEM**

**Pulmonary Embolism:** Walter G. Wolfe and David C. Sabiston. Philadelphia, Saunders, 1980. 180 p. (Major problems in clinical surgery, v. 25)

**Stress and the Major Cardiovascular Disorders:** Robert S. Eliot. Mount Kisco, N.Y., 1979. 176 p.

## **GASTROINTESTINAL SYSTEM**

**Gastrointestinal Surgery:** John S. Najarian and John P. Delaney. Chicago, Year Book, 1979. 724 p. \$43.50.

## **UROGENITAL SYSTEM**

**Cancer of the Genitourinary Tract:** Douglas E. Johnson and Melvin L. Samuels, ed. New York, Raven Press, 1979. 320 p.

## **ENDOCRINE SYSTEM**

**The Adrenal Cortex:** Don H. Nelson. Philadelphia, Saunders, 1980. 281 p. (Major Problems in Internal Medicine, v. 18)

## **NERVOUS SYSTEM**

**Headache:** Neil H. Raskin. Philadelphia, Saunders, 1980. 244 p. (Major problems in internal medicine, v. 19)

**Management of Peripheral Nerve Problems:** George E. Omer, Jr. and Martin Spinner. Philadelphia, Saunders, 1980. 1034 p. \$65.00.

**Therapeutics in Neurology:** Donald Calne. Oxford, Blackwell, 1975. 328 p. \$33.00.

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## **CMS Physician Health And Rehabilitation Committee Seeks Interested Members**

Behind heart disease, drug abuse is the number one killer of males in the United States. And it's estimated that approximately ten percent of each profession has a chemical impairment problem.

Statistically, that would mean that some 400 Colorado Medical Society members are so affected.

About a year and a half ago, the CMS Board of Trustees established a committee to develop a program for impaired physicians. The CMS Physician Health and Rehabilitation Committee has been looking at the methods and results of other state medical society programs and, on July 26, will hold the first of many training sessions to be offered statewide for members interested in becoming advocates — those who become personally involved in aiding chemically-impaired physicians.

All interested members are invited to participate in the training program because, according to the CMS PH&R committee members, physicians impaired by alcohol or drug abuse fare much better when help is given by peers, if not by friends or family.

The session will be led by Dr. John S. Avery, chairman of the Committee.

Statistics on physician impairment in Colorado show that, in the year between July 1977 and July 1978, the State Board of Medical Examiners took action against four physicians found to be offering poor quality care as a result of impairment. Three had licenses restricted or revoked for drug abuse; the fourth, for alcohol abuse.

By September, the committee hopes to have been directly involved in assisting at least one chemically impaired physician. The committee will accept referrals from all concerned persons.

The name of a physician may be referred to the committee with the confidence that, before any formal intervention is begun, there will be careful investigation and verification of impairment. The privacy and dignity of the referred physician will be strictly maintained. Chairman Avery said the object of the intervention program is not punishment, but rather inducement — supportive inducement to get help. And inducement to avoid the potentially harsh consequences of an untreated problem.

If you wish to offer help or make a referral, please call Dr. Avery in Boulder at 442-4660.

## SURVEY THE PHYSICIAN FAMILY

Please complete the following indicating your responses on a scale of 1 (totally disagree) to 10 (totally agree). Check one number.

1. Overall, I believe physician's families have problems no greater than other families of similar socioeconomic status.  

totally disagree	1	2	3	4	5	6	7	8	9	10	totally agree
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2. My marriage has met my expectations.  

totally disagree	1	2	3	4	5	6	7	8	9	10	totally agree
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3. My family usually has adequate time together.  

totally disagree	1	2	3	4	5	6	7	8	9	10	totally agree
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4. Pressures from patients and would-be patients make an enjoyable social life very difficult.  

totally disagree	1	2	3	4	5	6	7	8	9	10	totally agree
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5. Children in the family can have difficulty because of the frequent absence of the physician/parent.  

totally disagree	1	2	3	4	5	6	7	8	9	10	totally agree
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6. My sex life in the marriage is largely satisfactory.  

totally disagree	1	2	3	4	5	6	7	8	9	10	totally agree
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7. Sometimes I feel isolated and alone.  

totally disagree	1	2	3	4	5	6	7	8	9	10	totally agree
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8. If my marriage was deteriorating, it would be easy for me to seek professional help.  

totally disagree	1	2	3	4	5	6	7	8	9	10	totally agree
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9. When the marriage becomes dysfunctional, it is usually the spouse of the physician who is in greater need of psychological help.  

totally disagree	1	2	3	4	5	6	7	8	9	10	totally agree
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10. Describe any other concerns which you may feel affect the physician family.

Please check one

1. ☐ Male ☐ Female    2. ☐ Physician ☐ Spouse    3. ☐ Urban Practice ☐ Rural Practice    4. ☐ Age

PLEASE RETURN TO: Mrs. Kathy Thompson, President  
Colorado Medical Society Auxiliary  
1601 E. 19th Avenue  
Denver, Colorado 80218



# **110th Annual Session**

## **"DECADE OF THE EIGHTIES"**

# **Colorado Medical Society**

## **and Auxiliary**

**SEPTEMBER 24-27, 1980**

**THE BROADMOOR, COLORADO SPRINGS**

**REGISTRATION FORMS INCLUDED**

Admission to all events is by Registration Badge Only

### **WHO MAY ATTEND**

#### **DOCTORS, STUDENTS AND HOUSESTAFF**

All physicians including interns and postgraduate residents are welcome. Non-member physicians will be charged a registration fee of \$25.00. All students of medicine and housestaff are welcome to attend with no registration fee.

#### **DOCTORS' SPOUSES**

They are welcome at all meetings and events.

#### **ALLIED PROFESSIONS**

Dentists, Nurses, Pharmacists and other professional men and women allied with medicine are welcome to register and attend the sessions. Registration fee \$25.00.

#### **OTHERS**

Except for persons indicated above, others may register and attend appropriate parts of the Annual Session only when individually and continually accompanied and sponsored by a member of the Society.

#### **EDUCATIONAL SESSIONS**

The Scientific Session and the Practice Management program are presented by the Council on Professional Education and the Council on Socio-Economics of the Colorado Medical Society and The Office of Postgraduate Medical Education, University of Colorado Health Sciences Center, 4200 East Ninth Avenue, Denver, Colorado 80262.

As an organization accredited for continuing medical education, the University of Colorado Health Sciences Center certifies that this continuing medical education offering meets the criteria for 10 hours in Category 1 of the Physician's Recognition Award of the American Medical Association provided it is used and completed as designed.

#### **COLORADO MEDICAL SOCIETY OFFICE**

#### **BAILEY-STRATTA ROOMS**

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### **WEDNESDAY, SEPTEMBER 24**

**8:00 Registration Opens**  
am Lobby Level, Broadmoor West

**8:30 Colorado Foundation for Medical Care**  
am **Annual Meeting**  
Briefing Room, Broadmoor West

**9:00 Constitution, By-Laws and Credentials**  
am **Committee**  
West Ballroom, Broadmoor West

**9:30 House of Delegates First Meeting**  
am **Awards and Addresses**  
West Ballroom, Broadmoor West

**12 Reference Committee Chairmen**  
noon **Luncheon**  
Will Rogers Room, Broadmoor West

12 noon **CMS Grievance Committee with  
Chairmen of Component  
Grievance Committees**  
Pourtales Room, Broadmoor Main

1:30 pm **Reference Committee Meetings**  
**Board of Trustees and Executive Office**  
Ballroom D, West Ballroom  
**Constitution, By-Laws and Credentials**  
Academy Room  
**Interprofessional Relations**  
Carnation Room  
**Legislation**  
Cheyenne Mountain Room

**Medical Service**  
Casino Room  
**Professional Education**  
Prohibition Room  
**Public Health**  
White Eagle Room  
**Socio-Economics**  
Briefing Room

6:00- **Presidents' Reception**  
7:30 pm West Patio, Broadmoor West

7:15 pm **CMS Hosted Specialty Society  
Presidents' Dinner**  
Oval Room, Golf Club

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#### THURSDAY, SEPTEMBER 25

7:30 am **Registration Opens**  
Lobby Level, Broadmoor West

7:30- **COMPAC Breakfast - \$6.75 each**  
9:00 am Ballroom A and B, Broadmoor West  
Speaker: Paul Lauer, Assistant  
Director, AMPAC

Pre-reservations are urged (See CMS  
Advance Reservation form) Checks  
should be made to COMPAC (mark  
"for breakfast")

7:30 am **Judicial Council**  
Pike's Peak or Bust Room,  
Broadmoor West

8:30 am - **Physician's Learning Center,**  
**Scientific Exhibits,**  
5:30 pm **Auxiliary Displays**  
West Exhibit Hall

8:30 am - **Educational Sessions All Day**  
See detailed program  
4:30 pm

9:00 am **Physicians' Golf Tournament**

9:00 am **Auxiliary Program All Day**

11:00 am **Reference Committee Chairmen  
Luncheon Meeting**  
Ballroom D, West Ballroom

12 noon **CMS Past Presidents' Luncheon**  
**By invitation only**  
Pikes Peak or Bust Room,  
Broadmoor West

1:00 pm **Physicians' Tennis Tournament**

5:30- **CMS Reception Hosted by**  
7:00 pm **Presbyterian-Saint Luke's  
Medical Center**  
Lake Terrace Pool

7:00 pm **International Buffet and Dance**  
**Tickets - \$25.00 each - return**  
**reservation form to CMS**  
Main Dining Room

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#### FRIDAY, SEPTEMBER 26

7:30 am **Registration Opens**  
Lobby Level, Broadmoor West

7:30 am **Continental Breakfast for  
Program Participants**  
West Exhibit Hall

7:30- **Prayer Breakfast**  
8:30 am Don Reeves, Chairman of  
Denver Leadership Foundation  
Continental Breakfast  
**Tickets - \$6.00 each - see**  
**registration form**  
Ballroom D, West Ballroom



**COLORADO MEDICAL SOCIETY AUXILIARY  
FALL MEETING ADVANCE REGISTRATION  
September 24-27, 1980**

Name \_\_\_\_\_  
as you wish it to appear on meeting badge      please print

County \_\_\_\_\_

Address \_\_\_\_\_

Position held in State Auxiliary \_\_\_\_\_

Position held in County Auxiliary \_\_\_\_\_

CMS Auxiliary member ☐      Non-CMS Auxiliary member - \$5.00 ☐

Mail to: Mrs. J.R. Salata, 2902 Airport Road #106, Colorado Springs, CO 80910

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**LADIES LUNCHEON**

**Thursday, September 25, 1980      12:30 p.m., Ballroom A and B, Broadmoor West**

Cost: \$8.25 per person

Make check payable to Colorado Medical Society Auxiliary. Deadline for reservations is noon (12:00 p.m.), Wednesday, September 24, 1980.

Name \_\_\_\_\_ County \_\_\_\_\_  
please print

Address \_\_\_\_\_

Number of reservations \_\_\_\_\_ Amount enclosed \$ \_\_\_\_\_

Tickets may be picked up at the Ballroom entrance during the Social Hour. Mail reservation and check to: Mrs. J.R. Salata, 2902 Airport Road #106, Colorado Springs, CO 80910

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**AUXILIARY TENNIS TOURNEY REGISTRATION**

**Wednesday, September 24, 1980      Golf Club Tennis Courts      2:00 p.m.**

Entry fee: \$8.00

Make check payable to Colorado Medical Society Auxiliary. Play limited to 20 -- pre-registration is recommended.

Name \_\_\_\_\_ County \_\_\_\_\_  
please print

Address \_\_\_\_\_

Number of registrations \_\_\_\_\_ Amount enclosed \$ \_\_\_\_\_

Mail registration and check to: Mrs. Gary Nitz, 5 Westgate Road, Colorado Springs, CO 80906

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**CMS EDUCATIONAL PROGRAM  
THURSDAY, SEPTEMBER 25**

Two major topics will be treated  
in depth during concurrent sessions:

**8:30- ATHEROSCLEROSIS**

**11:30 am** Part I: The lesion: How and why  
it forms and risk factors.

A telephone presentation; out of  
town panelists will speak by ampli-  
fied telephone; twenty-two rural  
Colorado hospitals will be invited  
to participate by amplified phone.

Panelists: Jack C. Geer, M.D.,  
University of Alabama, Birmingham  
Roger Hamstra, M.D.  
Phillip Eaton, M.D., University  
of New Mexico School of Medicine  
John F. Mueller, M.D.  
Elmer Koneman, M.D., Moderator

Part: II: Diagnosis  
Prevention

Cheyenne Mountain and Casino Rooms

**8:30- INFECTION**

**11:30 am** Herpes Virus - A Real Pain  
James A. McGregor, M.D.

Prophylactic Antibiotic Usage and  
the High Incidence of Nosocomial  
Infections  
David Brandt, M.D.

Hepatitis  
To be arranged  
Carnation and Academy Rooms

**12:30- PRACTICE MANAGEMENT**

**4:30 pm**

**12:30 Luncheon**

\$10.00 per person; advance reser-  
vations required; seating is limited

Long Range Financial Planning:  
Time Value of Your Dollar  
Dr. Craig T. Callahan  
Dr. C. Thomas Howard

Health Insurance in the 80's -  
Physician Participation-Panel  
Mr. Chris Chandler  
Mr. Earl Rideout  
Mr. Frank Hayes, Jr.  
Mr. John Isham

The Plaintiff's Attorney: His View  
of Your Case  
Frank Plaut, J.D.  
West Ballroom D

**1:30- COMPUTERS FOR COLORADO'S  
4:30 PHYSICIANS**

**pm** Overview - Kevin P. Bunnell, Ed.D.

Computer Systems for Ambulatory  
Practices  
Jan Baumgardner, M.D.  
Larry Green, M.D.

Computerized Clinical Information  
Systems for Physicians  
David Steinman, M.D.

A Comprehensive Hospital Data System  
N. Kenneth Furlong, M.D.  
Briefing Room

**FRIDAY, SEPTEMBER 26**

**UPDATE SESSIONS**

**7:30 am Continental Breakfast for participants  
of educational programs**  
West Exhibit Hall

Two concurrent topics during each  
of three 45 minute sessions.

**8:00- Pelvic Inflammatory Disease OR**  
**8:45 am** James McGregor, M.D.  
**OR**  
Occlusive Vascular Disease  
W. Gerald Rainer, M.D.

**9:00- Peptic Ulcer Management**  
**9:45 am** Barry Frank, M.D.  
**OR**  
Diabetes Mellitus - Robert Alsever, M.D.

**10:00- Antibiotics**  
**10:45 am** David Brandt, M.D.  
**OR**

Management of the Obese Patient  
by the Primary Physician  
John F. Mueller, M.D.

**8:30- Joint CMS and Auxiliary Symposium**  
**10:45 am** Family Affairs (non-credit)  
Cheyenne Mountain and Casino Rooms

**11:00 Lanning E. Likes Memorial Lecture**  
**am** Detection and Diagnosis of Lung  
Cancer  
Geno Saccomanno, M.D.  
Briefing Room, Broadmoor West



**COLORADO MEDICAL SOCIETY AUXILIARY  
FALL MEETING, SEPTEMBER 24-27, 1980  
THE BROADMOOR**

**Registration:**

Wednesday, September 24, 8:00 a.m. to 4:00 p.m., Broadmoor West Lobby

Thursday, September 25, 8:00 a.m. to 4:00 p.m., Broadmoor West Lobby  
and 8:30 a.m. to 10:30 a.m., Golf Club, Mezzanine

Friday, September 26, 8:00 a.m. to 4:00 p.m., Broadmoor West Lobby

**Displays:**

All day Thursday and Friday morning, Broadmoor West, West Exhibit Hall

**WEDNESDAY, SEPTEMBER 24**

- |   |   |
|---|---|
| <b>2:00 Womens' Tennis Tournament</b><br>pm Broadmoor Golf Club Tennis Courts<br>Registration: 1:30 p.m., Tennis Courts<br>Entry Fee: \$8.00. Play limited to 20. | <b>6:00- Presidents' Reception</b><br>7:30 West Patio, Broadmoor West<br>pm |
|---|---|

**THURSDAY, SEPTEMBER 25**

- |  |   |
|--|---|
| <b>7:30 COMPAC Breakfast</b><br>am Ballroom A and B, Broadmoor West<br>See CMS Advance Registration Form   | <b>12:30 Luncheon</b><br>pm Ballroom A and B, Broadmoor West<br>Program and Awards Presentation |
| <b>9:00 Open Board Meeting</b><br>am Copper Room, Golf Club<br>Rolls and Coffee  | <b>2:30 County Presidents and Presidents-elect Meeting</b><br>pm Sun Room, Golf Club            |
| <b>10:15 General Meeting</b><br>am Copper Room, Golf Club<br>Keynote Address: Mrs. Harvey S. Dvorsky, AMA Auxiliary President-elect                                  | <b>5:30 Reception</b><br>pm Lake Terrace Pool<br>Sports Awards                                  |
| <b>11:45 Social Hour, Cash Bar</b><br>am Ballroom A and B, Broadmoor West<br>Hostesses: Past State Auxiliary Presidents (Shuttle from Golf Club every eight minutes) | <b>7:00 International Buffet</b><br>pm Main Dining Room<br>See CMS Advance Registration Form    |

**FRIDAY, SEPTEMBER 26**

- |  |  |
|--|--|
| <b>7:30- Prayer Breakfast</b><br>8:30 Ballroom D, Broadmoor West<br>am See CMS Advance Registration Form | <b>8:30 Joint CMS and Auxiliary Symposium</b><br>am "Family Affairs"<br>Cheyenne Mountain-Casino Rooms<br>Broadmoor West |
|--|--|

11:00  
am

**Lanning E. Likes Memorial Lecture**  
Briefing Room, Broadmoor West  
See CMS Educational Program

8:00- **Scientific Update Programs**  
10:45  
am

12 **Caucus Meetings of Component**  
noon **Medical Societies**

8:30- **Joint CMS and Auxiliary Symposium**  
10:45 **Family Affairs**  
am Cheyenne Mountain - Casino Rooms

1:30 **Constitution, By-Laws and**  
pm **Credentials Committee**  
West Ballroom

8:30 **Scientific Exhibits, Physicians'**  
am - **Resources Learning Center, Auxiliary**  
2:00 **Displays, Legislating Medicine**  
pm West Exhibit Hall

2:00 **House of Delegates Second Meeting**  
pm **Election and Installation of Officers**  
West Ballroom

10:45 **Coffee Break**  
am West Exhibit Hall

11:00 **Lanning E. Likes Lecture**  
am - **Detection and Diagnosis of**  
noon **Lung Cancer**  
Geno Saccomanno, MD  
Briefing Room, Broadmoor West

5:00 **ACEP Board Meeting**  
pm Fountain Area, Main Dining Room

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Scientific Exhibits, Physicians' Learning Resource Center and Auxiliary Displays will be set up in the West Exhibit Hall all day Thursday and until 2:00 p.m. Friday. Coffee breaks during the educational programs will be in the West Exhibit Hall.

On Friday the CMS Council on Legislation will meet informally with legislative keymen from component societies to discuss 'Legislating Medicine'. Anyone interested in the legislative process of the Colorado Medical Society is invited to come to the West Exhibit Hall on Friday to discuss this important subject.

### **ANNUAL COLORADO MEDICAL SOCIETY TENNIS TOURNAMENT**

One half day of play, Thursday afternoon, September 25. Play will be between 1:00 and 5:00 p.m. Registration fee: \$7.50. - does **not** include court fee. (\$8.00 an hour for singles; \$10.00 an hour for doubles). A drawing will take place beginning at 8:30 a.m. for those of you who have not pre-arranged for a partner. You must be pre-registered and must be present at the drawing. Play will be between players of equal level.

Two-level Competition: A Level - consistent players  
B Level - average players

### **THIRTEENTH COLORADO M.D. INVITATIONAL GOLF TOURNAMENT**

Sign up at the Society's Registration Desk - Broadmoor West Lobby.

Entry Fee: \$20.00 per person - does **not** include green fee - \$16.00, or cart for two - \$14.00.

Play will be on the East Course.

One day of play, Thursday, September 25. Since many players do not have established handicaps, play will be on the Calloway System. There will be recognition for low gross scores. Starting times have been reserved on the Course from 9:00 a.m. to 11:00 a.m. Play is to be in foursomes arranged by contestants.

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**Your check made payable to the Colorado Medical Society should reach the Society in Denver by September 18. Return advance registration forms for golf and tennis.**



**CMS REGISTRATION FORM FOR SEPTEMBER 24-27, 1980 ANNUAL SESSION**

**Please be sure your name, address and phone number are on the reverse of this page.**

**REGISTRATION FOR NON-EDUCATIONAL EVENTS**

☐

**Thirteenth Colorado Physicians' Invitational Golf Tournament - September 25**  
9:00 a.m.-5:00 p.m.

Name \_\_\_\_\_  
please print

Address \_\_\_\_\_

Partner \_\_\_\_\_

Entry fee: \$20.00 per person - does not include greens fee (\$16.00 per person), nor golf cart (\$14.00 for two people). See information included in this program.

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☐

**Annual Colorado Medical Society Physicians' Tennis Tournament - September 25**

One-half day of play - Thursday afternoon, 1:00 p.m.

Name \_\_\_\_\_  
please print

Address \_\_\_\_\_

Partner \_\_\_\_\_

Registration fee \$7.50 Check must be received by September 18th.

Indicate level of competition: A LEVEL (consistent players) ☐  
B LEVEL (average players) ☐

\*\*\*\*\*

☐

**Colorado Medical Society International Buffet - September 25 - 7:00 p.m.**

Name \_\_\_\_\_  
please print

Address \_\_\_\_\_

Banquet is \$25.00 per person Reserve \_\_\_\_\_ (#) tickets

\*\*\*\*\*

☐

**Prayer Breakfast - September 26 \$6.00 per person 7:30 a.m.**

\*\*\*\*\*

**Total Enclosed (for educational programs and non-educational events) \$\_\_\_\_\_**

Please make check payable to the Colorado Medical Society. Mail this form and your check to:  
Irene E. Hobart  
Colorado Medical Society  
1601 E. 19th Avenue  
Denver, Colorado 80218

\*\*\*\*\*

**COMPAC Breakfast - September 26 \$6.75 per person 7:30 a.m.**

Please make check payable to COMPAC (mark "for breakfast").  
Mail this form and separate check to Irene Hobart as indicated above.

(see other side to register for golf, tennis, banquet, prayer breakfast and COMPAC breakfast)

Address \_\_\_\_\_

Phone \_\_\_\_\_

Irene E. Hobart  
Colorado Medical Society  
1601 E. 19th Avenue  
Denver, CO 80218

☐ 8:30 a.m. to 11:30 a.m.  
ATHEROSCLEROSIS

**OR**

☐ 8:30 a.m. to 11:30 a.m.  
INFECTIONS

☐ 12:30 p.m. to 4:30 p.m.  
PRACTICE MANAGEMENT  
Program begins at 12:30 with  
a luncheon presentation.  
\*\$10.00 per person

**OR**

☐ 1:30 p.m. to 4:30 p.m.  
COMPUTERS FOR  
COLORADO'S  
PHYSICIANS

8:00- ☐ Pelvic Inflammatory Disease **OR**  
8:45 ☐ OR  
am ☐ Occlusive Vascular Disease

8:30-  
10:45  
am

☐ Joint CMS and Auxiliary  
Symposium  
Family Affairs  
(non-accredited)

9:00-  
9:45  
am

☐ Peptic Ulcer Management  
OR  
☐ Diabetes Mellitus

10:00-  
10:45  
am

☐ Antibiotics  
OR  
☐ Management of the Obese Patient  
by the Primary Physician

11:00 am-12:00 pm

\*Make check payable to Colorado Medical Society

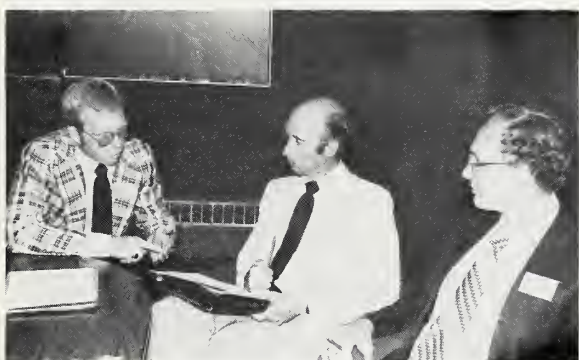


In June the Colorado Medical Society sponsored its first Component Society Officers' Meeting, providing an opportunity to the component members to have first-hand information about Society activities and services, and then respond with their own suggestions or queries.

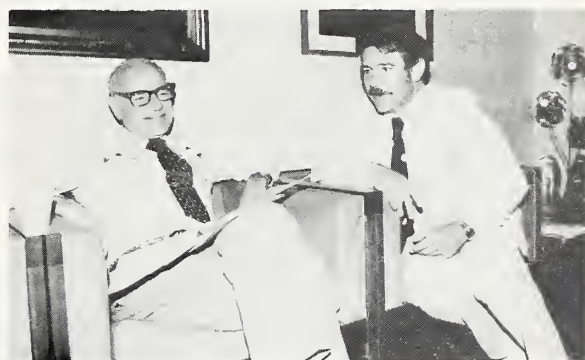
The morning half of the meeting was an "audience" type of gathering, as the officers of the Society and Foundation, along with some staff explained the issues most important to the Society as a whole.



Workshop leaders (hairmen) were briefed at a morning meeting, prior to the general session beginning. Dr. K. Mason Howard, the day's Chairman, explained the purposes and goals of the individual workshops. Seated, from l to r, Drs. Robert Sawyer and Ray Witham, E.V.P. Jerry Bowman, Dr. Howard, and workshop chairmen, Drs. Bob Johnson, Bill Ezell, Jerry Hansen, Jim Urban and Ted Sills.



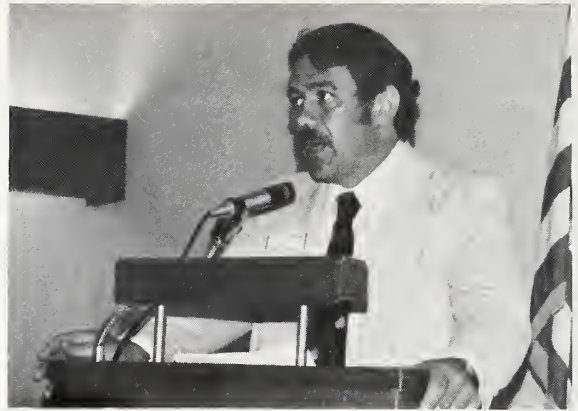
Many participants felt that the get-together between component members and staff and the officers and staff of CMS/CFMC was the most important aspect of the meeting. During the morning briefing, (l to r) CMS Director of Finance Chris Stein talked with Dr. Bob Johnson concerning services now offered by CMS/CFMC and what can be done to better these services, including member professional liability insurance. Listening is Brian Stutheit, Director of the CMS Professional and Patient Relations Council.



One of those Board of Trustees who made a lengthy trip to Denver to participate and to contribute was Dr. Hanns Schwyzer from Trinidad (Las Animas County), as he talked with Dr. Robert Sawyer of Denver, Chairman of the Board of the Colorado Foundation for Medical Care. Dr. Schwyzer probably traveled the furthest; Dr. Sawyer probably traveled the least (his offices are 2 short blocks from the CMS/CFMC headquarters building).



R. B. Bowman, Executive Vice President of CMS/CFMC, gave an "executive report," highlighting the primary goals of the two organizations, based on his own purview. Bowman cited statistics from his experience with physician-association business in California, and compared the concerns of those professionals with the concerns he had sensed in Colorado medical circles. Thus, he said, he was presenting the CMS/CFMC Board of Trustees with a "shopping list" of needs for the two organizations for the next ten years.



Dr. Robert Sawyer, Chairman of the Board of the Colorado Foundation for Medical care, as he addressed the gathering on where the Foundation had been, what it is and where the Foundation is going.



Dr. Richard Bedell, Speaker of the House, listens as he awaits his opportunity to tell the audience of the new House of Delegates Handbook, which was included in the guest information packets.



Joseph L. Kovarik, MD, Alternate Delegate to the American Medical Association, was on hand to answer questions and to explain some of the philosophies of the AMA. Dr. Kovarik indicated a much more productive year for members of AMA because of improved communications (no, not increased communications) between AMA and the individual members of CMS. Much of the concern voiced for Colorado's very low AMA membership was the idea that AMA does little for the good of the individual member. Kovarik and others brought forth several examples of the AMA's good works on a localized basis.



Gathered in the lobby between sessions were Drs. N. Curtis Kimball (l) and William W. Ezell (c), both of Sterling, Colorado, talking with the CMS Lobbyist, Carol Tempest. It is doubtful they could be talking about very weighty legislative matters, considering the pleasant appearance on their faces.





In the lobby during the pre-session coffee, CU Medical School Student Medical Society President, Joseph Jiminez (l) talked with CMS's Socio-Ec Council Director Robert FitzGerald. They were probably discussing the merits of kinetic potential or white-water rafting, or racquetball, all of which they can claim have some medical or physical relationship.



CMS Legal Council Larry Wood brought the group a short but effective description of three of the major concerns to physicians: anti-trust laws, malpractice and doctor immunity in cases of psro involvement. Each of the key speakers delivered their remarks from prepared text, and a copy of each address was made available to the audience, so they could take the material back to their society and share the contents with fellow members. If you would like information, or copies of these talks, ask your local executive officers, or ask your own component officers.



Giles Toll, M.D., Chairman of the CMS Organizational Study Committee, outlined the proposed changes in CMS By-Laws which will be put before the House of Delegates at the September Annual Session. Dr. Toll's committee has been working the revision of the By-Laws for several months to make the proposed changes into a fully-researched package that the Delegates will not have to spend a great deal of time over in committee. Dr. Toll's charge to his own OSC group was to reshape the By-Laws to more closely conform to the business world of the 1980 decade.



Discussion of the workshop agendas included a brief session between (l to r) CMS Communications Director Bill Pierson and Dr. Bill Ezell, who coordinated the Communications workshop.



Other staff members of both the components and CMS had a chance to get better acquainted, though it hardly seems necessary on the part of the many good friends/staff members from components within metro Denver. Brian Stutheit (l) of CMS-PPR was talking with Cleo Lucas (c), Executive Director of Clear Creek Valley as she talked with Ginny Torrey (r), also of the CMS Professional and Patient Relations Council staff.

"All That Support!" That was the theme of the CMS Auxiliary President Kathy Thompson, and she showed the participants a variety of support. None, however, compared to the support provided Colorado physicians by the Auxiliary members. Kathy's group has already made an effective program plan for the coming year, and has pledged to carry on the good works of her predecessor, immediate past-president Betsy Becker.



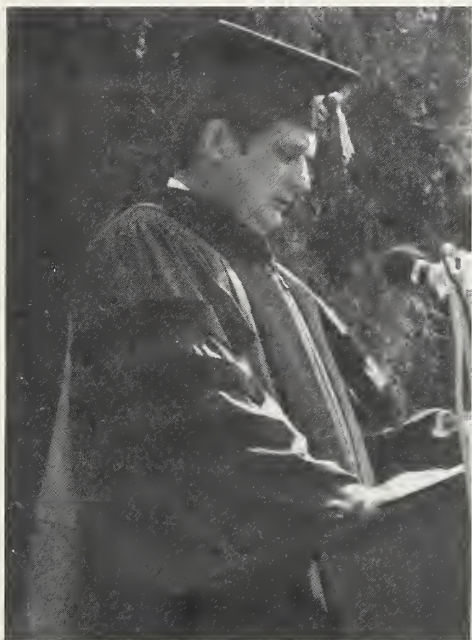
It was not a salute, but part of a ritual: Kathy Thompson got the group of 60-70 people on their feet when she introduced an exercise for the 7th inning stretch. She even got them singing the praises of "health power."

Jerry Bowman and Dr. Mason Howard are intent in the discussion of topics for the day's workshops at the early morning briefing. As the President-elect, Dr. Howard said he felt the component officers' meeting was going to be helpful in continuity of Society affairs, carrying out the programs begun by Dr. Ray Witham's administration, as well as to set new goals for the year to come.





The University of Colorado School of Medicine held its Commencement Exercises in late-May, with 114 persons receiving their Doctorate of Medicine, 24 awarded the D.D.S., 140 nurses including both Bachelor's and Master's degrees. Three persons received BA degrees as Child Health Associates, 13 as Dental Hygienists, 27 graduated as Medical Technologists, including Medical Scientists, 31 graduates received Master of Science degrees, and 9 were awarded the degree of Doctor of Philosophy in Basic Science. The ceremonies were held at the Health Sciences Center in excellent out-of-door weather on the morning of May 24th.



University of Colorado School of Medicine Dean M. Roy Schwarz, MD, introduced each of the candidate-graduates as they came forward to receive their diploma and to be hooded.



Ray G. Witham, MD, President of Colorado Medical Society, participated in the ceremonies, here hooding Naomi Castillo of Denver. Ms. Castillo is now in her first year family practice residency at the University of Kansas, Kansas City, Kansas.



Dignitaries from the Colorado medical, executive and educational communities participated in the hooding ceremonies of the School of Medicine graduates. On the dais (from left to right, back row) are Jack Nolte, PhD, Commencement speaker; C. Henry Kemp, MD, and Mrs. Ruth Kemp, MD, School of Medicine faculty members, who participated in the hooding of their daughter; Robert H. Fennell, MD, faculty, who hooded his son; Norman Joseph, MD, President of the Medical School Alumni Association; William Reimers, MD, Executive Medical Director of the Colorado Permanente Group; and, (left to right, front row) Ray G. Witham, MD, President, Colorado Medical Society, and the Honorable Nancy Dick, Lieutenant Governor, State of Colorado.

# Primary care in Colorado

## A Needs Assessment

George E. Fryer, Jr.; MA, MSW; Diane Patrick, MA, and Richard D. Krugman, MD,  
Denver, Colorado

*Recently implemented programs offer hope for relief for residents of Colorado's medically underserved rural communities. But consideration of health manpower requirements only of underserved areas, and use of dated federal criteria in so doing, results in understatement of this state's need for additional primary care physicians. This report summarizes the physician manpower status of the 50 of 63 counties in Colorado served by the University of Colorado's Area Health Education Center Program (known as SEARCH-Statewide Educational Activities for Rural Colorado's Health). The data are current as of August, 1979, but equally important is the methodology described for updating and clarifying the multiple national and state files.*

### Introduction

In 1970, the Carnegie Council on Higher Education in Medicine and Dentistry issued a report, part of which suggested that the significant maldistribution of physicians, particularly in the rural areas of the United States, could be partially alleviated by the development of Area Health Education Centers throughout the country.<sup>1</sup> These centers were envisioned as being remote from but having contractual agreements with University Health Sciences Centers such that students and residents would have educational experiences in offices, clinics, and hospitals in the area, and rural practitioners would have easier access to continuing education. It was hypothesized that the former would help attract new manpower, while the latter would help retain those health professionals already there.

In 1971 the United States Congress passed legislation which authorized the Department of Health Education and Welfare to enter into contracts with Schools of Medicine for the purpose of developing Area Health Education Center Programs.<sup>1</sup> Eleven schools were awarded five year contracts in 1972. The success of these eleven programs led the Congress to authorize

further contracts in the Health Professions Education Assistance Act of 1976. Four programs were funded in 1977 (including the Colorado SEARCH Program), five in 1978 and three in 1979.

A maldistribution of physician resources in Colorado had developed both geographically and by specialty. Although the absolute number of physicians in the state was adequate to meet accepted national standards, most of these physicians were concentrated in the communities along the front range of the Rockies. Further, there was a need for relatively more family physicians for the smaller communities than specialists. In order to address these needs, the state began to encourage and support community family medicine residency programs to increase the supply of family physicians, and the SEARCH Program obtained Federal and State funds to affect the geographic maldistribution by developing four area health education centers.

As a prerequisite to a meaningful evaluation of the SEARCH Program we began a determination of the magnitude of the maldistribution problem in Colorado. It soon became clear that while the availability of primary health care services to rural residents may generally be unsatisfactory, there are certain sparsely populated counties that have much less of a problem than do others. We therefore decided to do a primary care needs assessment.

Our study differs somewhat from previous assessments, most of which have been predicated solely on Federal criteria which use a physician to population ratio of 3500:1 as a critical level. Since it is our observation that the demand for health services still exceeds the present supply for most of the state, our analysis includes consideration of the existing availability of primary medical care in Colorado's rural communities, and prescribes the number of additional physicians that will be required by 1985 if that present level of



availability is to be maintained.

## Methods

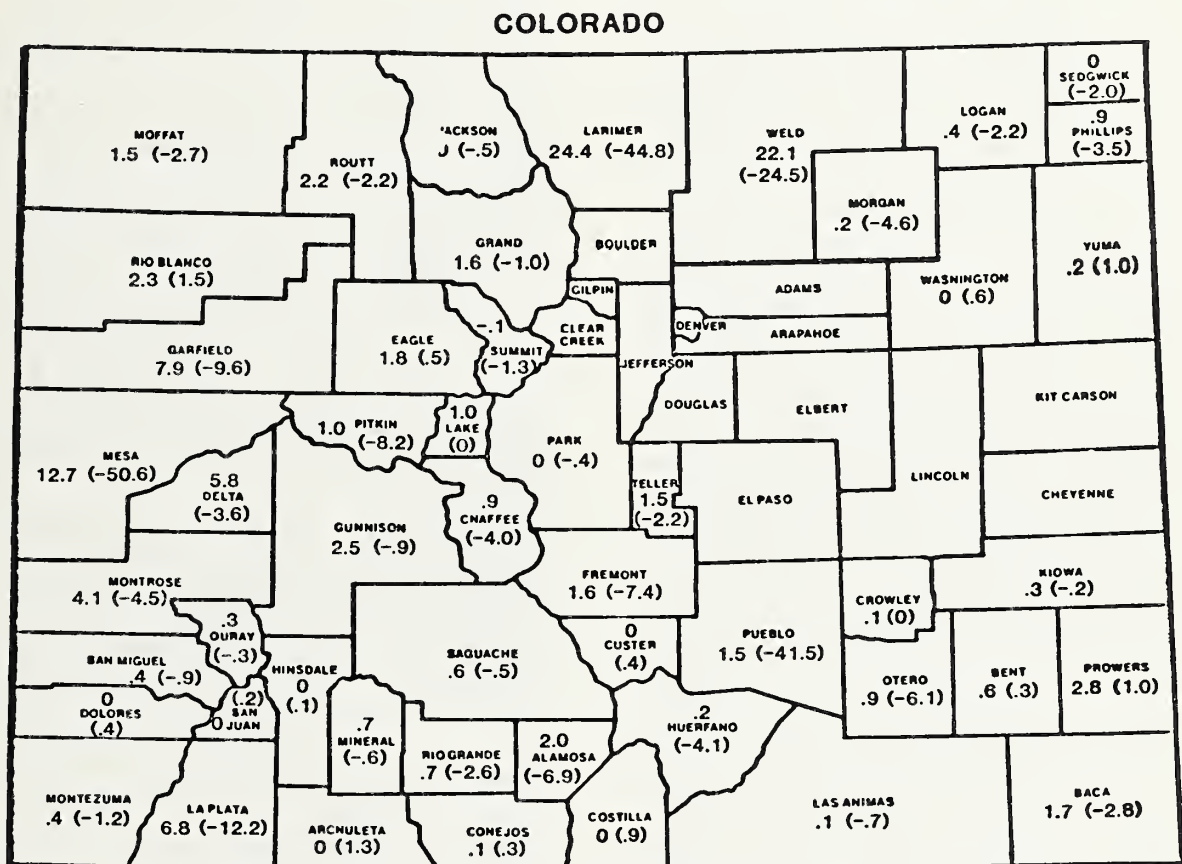
At the outset, we decided that only the SEARCH Program service area would be examined (See Figure 1) for the following reasons:

- The program's service area encompasses 50 of the state's 63 counties, 17 of the 20 counties Federally designated as medically underserved, and over 90 per cent of Colorado's rural residents.
- The SEARCH Program's resources would be

directed primarily toward health manpower deficiencies shown within the bounds of its service area during the succeeding five years.

- The counties in which the program's four Area Health Education Centers are located and several other counties within the program's service area were sufficiently supplied with health professionals to illustrate the contrast between the manpower rich areas of the state and those more disadvantaged.
- The benefit to our analysis of inclusion of the additional 13 counties would be modest in comparison to its cost.

FIGURE 1: PRIMARY CARE PHYSICIANS (MD AND DO) NEEDED BY 1985



Number in parenthesis represents additional primary care physicians needed by 1985 to preclude the county's designation as a medical manpower shortage area by that year.  
 Number outside parenthesis represents additional primary care physicians needed by 1985 to maintain the present primary care physician to population ratio in that year.  
 Primary care includes general practice, family practice, general internal medicine, general pediatrics, and OB/GYN.

Two major data categories contain items critical to our findings. The first of these is population. It is the number of people, and their demands for health care, which govern the need for physicians in the various geopolitical divisions of this or any other state. Official popu-

lation estimates for 1979 and projections for 1985 are published by the Colorado Division of Planning in accordance with state and federal mandate. We used figures generated in August, 1979, by that agency. The data were the first released since 1976 and were based on 1979

compilations which were subjected to regional review.

A word of caution should be noted. Naturally, the finer the unit of analysis, the less reliable the figures. Statistical population estimates for a given year range from 54 to 89 per cent among the state's planning and management regions<sup>2</sup> and are even lower for county units. Nevertheless, these recent projections are the product of an accepted model, account for the expected impact of energy development, and their adoption is required for all state agencies.

A serious shortcoming of this population base is its lack of age and sex-specificity. Age in particular is a strong determinant of the need and demand for health services. The Colorado Division of Planning's 1976 product included provision for these variables. But their deletion in this year's publication is understandable in that nine years have elapsed since the 1970 decennial census upon which very fine determinations would have to be based. The 1980 census insures relief in the fairly immediate future.

The other critical data category is physician manpower. Efforts to identify precisely the practice locations of physicians and measure the service they render have been both numerous and disappointing. A number of agencies survey physicians periodically, but none have been able to satisfy the data needs of planners, government officials and others whose duties include policy prescription and the allocation or regulation of resources. Primary data collection was not done in this assessment. Rather, a concerted attempt was made to collate and refine the work of various data gathering agencies.

The limitations imposed by the lack of either accuracy or comprehensiveness in individual data sources were partly overcome in this assessment. The manpower data base used was comprised of items from each of the following sources: Colorado Board of Medical Examiners, Colorado Department of Health, Colorado Medical Society, American Medical Association, National Health Service Corps, Colorado Society of Osteopathic Medicine, and the Western Colorado Health Systems Agency.

The data file collected from these sources was then checked by: (1) review of local telephone directories, (2) utilization of community nurses to verify the presence of a physician in a given locality, and (38) distribution of a short survey to all physicians in the 50 counties with envelopes marked "Do not forward-address correction requested". This method enhanced the

quality of the organizational file mentioned above.

We believe that the four-month duration of the data collection compromised somewhat the accuracy of the file in light of the mobility of physicians in Colorado. As a result, we cannot conclude that the physician distribution described here is valid for a single moment. Rather, this manpower analysis can be said to portray with considerable accuracy the general distribution during the four-month period from June-September 1979.

## *Discussion*

There are certain findings pointedly supportive of the argument that the relative inaccessibility to primary health care suffered by Colorado's rural residents results from maldistribution rather than a shortage of physicians. The most striking is that 45.3 per cent of the 558 primary care physicians serving the area could leave without replacement by 1985 and the fifty counties taken as a single unit would still not meet the 3500:1 Federal criterion for designation of medical manpower shortage areas. It then follows theoretically, that the 306 physicians remaining could be geographically distributed in such a manner as to preclude designation as a manpower shortage area of any one of the counties. Practically, however, that analysis is absurd.

Given the present level of activity of National Health Service Corps personnel, only thirteen counties will require additional primary care physicians in order to maintain a ratio more favorable than the 3500:1 population to primary care physician standard. Six of those counties lie in the western part of the state. The basic requirements of the thirteen counties could be met with only 8.2 additional full-time primary care physician equivalents of service, and by as few as fifteen more physicians (See Figure 1).

As useful as these facts might be for identification of Colorado's most severely underserved areas, and planning and programming to meet the very basic health care needs of the individuals residing there, they clearly understate the need for primary care physicians perceived by the general public. The deterioration of the primary health care delivery system represented by an increase to the criterion ratio of 3500:1 would unlikely go without notice and certainly would do little to elicit support for



such redistribution among the large majority of the citizens of this program's service area. We believe that the consumer's perception of health care standards is in no small part a function of the medical service to which he/she has become accustomed. This level of service will in most cases bear little resemblance to that minimally prescribed by Federal formulation. An individual who normally experiences a waiting period of thirty minutes to see a physician will probably not be pleased with the prospect of waiting two hours or two days, even though the latter period will not seem excessive to most residents of medically underserved communities.

For this reason, consideration of the number of physicians and primary care physicians required to maintain present accessibility is more important for counties whose population to primary care ratios do not currently approximate 3500:1 or greater. Although one cannot assume that population to physician ratios equate with average patient waiting time for physician visits, or with other utilization indices, it may be reasonable to assume that the relationships between the ratio and these variables will be strong.

Community needs are then shown in a new light. Many of the more densely populated areas which will experience significant population growth are in need of large numbers of additional health care providers even though they appear relatively overserved now. These figures are based on absolute magnitude of population growth and present levels of medical service rather than improvement in level of service or per cent increase in population. Perhaps no single consideration so speaks to the need for population-based planning.

Primary care physicians for the purposes of our analysis are MD's and DO's in family/general practice, general pediatrics, general internal medicine, and OB/GYN. In the past, attempts have been made to assess the need of certain communities for the services of a particular type of primary care practitioner. The outcome of any such examination must be viewed with some skepticism. The practice profile of the FP/GP accounts for most of the difficulty in performing these analyses. Pediatricians and internists have more or less age-defined patient populations. Family and general practitioners do not. It has been found that 18.8 per cent of all visits to FP/GP's are made by

members of the pediatric population.<sup>3</sup> The number of pediatricians needed to serve a given population, or the number of internists required is contingent on knowledge of the number of FP/GP's that are or will be in practice in service to that same population. The woes of the analyst are only compounded by the fact that the productivity figures for family and general practitioners vary substantially from those of pediatricians and internists.<sup>3</sup>

There is, however, cause to award special value to the services of the FP/GP in determining the primary care needs of Colorado's rural residents. Just less than one-fourth of all physician visits in the United States are made for service to the pediatric population.<sup>4</sup> For a county of modest population, unless its pediatric composition is significantly disproportionate, it may not be feasible for a pediatrician to establish practice there. There are a great many rural counties in this state in that category. It can be concluded that the family/general practitioner brings a much needed flexibility to the primary health care delivery system of sparsely inhabited rural areas. The presence of FP/GP's negates the necessity for age-specific consideration of primary care specialty balance in the area's health care delivery system.

Although not in accordance with a previously conceived plan, physicians have apparently weighed population size and age composition in arriving at career decisions. For the counties of the SEARCH Program service area with ten or fewer physicians serving the county, 68.9 per cent of all physicians are family/general practitioners. For counties with more than ten physicians the comparable percentage is only 25.7 per cent.

The contribution of osteopathic physicians to this state's rural health care delivery system is noteworthy. Nationally less than 0.3 per cent of all physician visits have been made to osteopaths, and that figure represents a steady decrease in their percentage of total visits since 1966.<sup>5</sup> But DO's comprise about 6.3 per cent of all physicians practicing in SEARCH's fifty county service area, and some 82.5 per cent of these osteopaths deliver primary care.

The figures associated with the preceding computation of additional physicians needed to maintain current levels of accessibility to primary health care are relatively stable for counties having larger populations. Definite long-term planning can be done to meet their needs. On the other hand, for the more sparsely inha-

bited counties for whom designation as a medical manpower shortage area either has occurred, or is a distinct possibility in the not too distant future, programming may prove more difficult. Their small, but critical figures associated with achieving population to primary care physician ratios more favorable than 3500:1 are much less stable and may be rendered meaningless literally overnight; in some cases even by a single physician relocation.

Some resignation may be in order to the apparent futility of attempting to encourage physicians to establish practices in communities of less than a certain number of residents. Studies have shown that communities that do not have a sufficient number of residents to provide physicians,<sup>6</sup> as well as mid-level practitioners,<sup>7</sup> with desired income potential, cannot be expected to entice these professionals to their towns to establish practice. This phenomenon can be documented here in Colorado. Of the 89 incorporated towns of the SEARCH Program service area which do not have the services of a physician, the average population is only 446.

## **Conclusions**

Our analysis has focused exclusively on the SEARCH service area. It has been characterized by relative health manpower wealth, with only a few thinly populated rural areas requiring our immediate attention. An absolute manpower shortage has been dismissed almost out of hand. But the examination of population to physician ratios projected nationally somewhat belies such representation of our problem. Only Mesa County, among the counties of the SEARCH service area has a population to physician ratio lower than that projected for the nation in 1980 (502:1).<sup>8</sup> And although the national projection for 1980, and that for 1990 (413:1),<sup>8</sup> together have become the cornerstone of the argument that the United States will soon experience a very real excess of physicians, Colorado physician figures cannot be effectively viewed totally outside national context.

Resolving the maldistribution of health care professionals should be undertaken with a sense of urgency. It stands clearly as the most serious of our manpower problems, and borders on crisis. Two programs implemented for that expressed purpose are those of SEARCH and the National Health Service Corps.

Efforts to redistribute physicians who have been in practice for some time are impractical. Their future relocation, if any, will be governed by the same factors as in the past and is as likely to exacerbate the problem as contribute to its solution. Necessarily then, the focus should be with the career decisions being made by medical students and residents. The difficulties associated with relocation of practice are often enough to preclude an established physician from seriously weighing such an option. Students and residents are not constrained in this regard.

Use of the medium of education holds promise. It is employed by both the SEARCH Program and that of the National Health Service Corps. SEARCH sponsors the placement of students and residents in rural areas. It further subsidizes and otherwise supports professional activities in underserved areas which enhance community attractiveness to health care personnel seeking practice location. The community's capacity to retain health manpower can also be increased as a result of those same activities. A number of states have instituted similar programs. Their accomplishments have been evaluated by the Carnegie Commission.<sup>1</sup>

The National Health Service Corps has sites scattered throughout this and other states. They are manned by health care professionals repaying tuition loans through their service to underserved populations. While the retention rate of these personnel upon completion of their obligation was at first disappointing, it has risen steadily to 47 per cent.<sup>8</sup> This is the percentage of placements remaining in service to the community for at least one year after fulfilling their two year commitment.

It will require concerted action to bring relief to Colorado's medically underserved population. But a better appreciation of the parameters of their plight is in evidence, and remedial efforts are now underway. The success of these efforts can be meaningfully measured through later periodic reexamination of the indicators presented in this document. ●

Supported by HRA Contract 232-79-0060.



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- <sup>2</sup> Colorado Division of Planning, *Population Estimates and Projections*, Series CP-25, No. 79(A)-1 (1979).
- <sup>3</sup> U.S. Department of Health, Education, and Welfare, *Physician Manpower Requirements*, DHEW Publication No. (HRA) 78-10 (1977).
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- <sup>6</sup> Muscovice, Ira and Rosenblatt, Roger. "The Growth and Evolution of Rural Primary Care Practice: The National Health Service Corps Experience in the Northwest", discussion paper, University of Washington, 1978.
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- <sup>8</sup> Scheffler, R.M.; Yoder, S.G.; Weisfeld, N.; and Ruby, G. "Physicians and New Health Practitioners: Issues for the 1980's", *Inquiry* 16 (Fall 1979): 195-229.

## What is the AAAHC?

Many physicians around the State have recently received information about the Accreditation Association for Ambulatory Health Care, Inc. Since this is a new organization, doctors may be confused about what the AAAHC is and what it does.

Soon after the Accreditation Council for Ambulatory Health Care of the Joint Commission on Accreditation of Hospitals (JCAH) was dissolved last year, three of the five charter members of the original Accreditation Council for Ambulatory Health Care decided to continue the accreditation program under the aegis of the newly-formed AAAHC. These groups include the American Group Practice Association (AGPA), Group Health Association of America (GHAA), and Medical Group Management Association (MGMA). Joining these three groups as charter members of the new accrediting body are the American College Health Association (ACHA), Free Standing Ambulatory Surgical Association (FSASA), and the National Association of Community Health Centers (NACHC).

When the program was under the auspices of JCAH, it was a voluntary activity. This continues to be true. The object of the AAAHC is to provide peer-based assessment to aid in an ongoing process of self-evaluation.

## What is the Incentive for AAAHC Accreditation?

If an ambulatory care center is AAAHC-accredited, it is entitled to accept assignment for Medicaid and Medicare payments. Since most ambulatory care centers do not accept assignment, there is not the strong incentive for ambulatory centers to be accredited that there is for hospitals. (However, up until 1975, when reimbursement for Medicaid and Medicare to hospitals became linked with JCAH accreditation, hospital accreditation was strictly voluntary also.

The positive points of the accreditation program are peer review and educational benefits. The process is a 1-½ to 2-day on-site visit by two physicians and one administrator. Standards examined during the visit include the areas of patient rights, administration, quality of care, medical records, surgical services, educational activities, etc. It is a vigorous process.

There are no ambulatory care centers in Colorado that are currently AAAHC-accredited. However, several state BC/BS programs are exploring the possibility of linking reimbursement with AAAHC accreditation. If this linkage were made in Colorado, the number of accredited ambulatory care centers would certainly grow. This association for reimbursement may first appear with ambulatory surgery centers.

More information about the AAAHC can be obtained by contacting the Executive Director, Ronald Moen, (312) 676-9610.



### HILTON HEAD GENERAL MEDICINE CONFERENCE

Sponsored by Beth Israel Hospital, Denver.  
October 12-16, 1980.  
Hilton Head Island, South Carolina

**20 hours AMA Category 1 & AAFP  
Prescribed credit.**

**Fees: \$240 general, \$165 residents.**

**Topics: coronary artery disease, diabetes  
and endocrinology, infectious diseases, and  
pulmonary diseases.**

For registration & housing information, contact:  
Beth Israel Conference Program  
P.O. Box 11366, Denver, CO 80211  
Phone (303) 629-5333 or  
(800) 525-5810 (toll-free outside Colorado)

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# practice management

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Students at the University of Colorado Medical School have had practically no systematic education on cost containment. The Cost Containment Education Committee, chaired by Dr. Carlos Martini, is now preparing a cost containment curricula to educate new physicians. The goal of the course is to assist the physician to practice medicine in a cost conscious atmosphere.

In the future, regulatory agencies may require physicians to be familiar with third party practices and patient fee requests. With this in mind, the Committee will consider the following objectives:

1. To acquaint physicians with practice problems presented by private and public third parties.
2. To affect the behavior of physicians in the processes of diagnosis and treatment;
3. To correlate the condition of the patient to an appropriate medical setting and to an appropriate institutional length of stay;
4. To institute physician office practice management concepts and legal concepts into the mainstream educational experience, and
5. To present preventative medicine concepts which have demonstrated cost effectiveness.

Committee members: *University of Colorado Health Sciences Center*: Carlos Martini, MD, Neil Chisholm, MD, Barbara M. Harley, MD, Paul Redstone, MD, Robert Schlenker, MD, John W. Woodward, MD, Steven Dubovsky, MD, *Colorado Medical Society*: Robert M. Fitzgerald; *Blue Cross/Blue Shield of Colorado*: Willis L. Bennett, MD, *CEIS*: Robert Elliott, MD, *Veterans Administration Hospital*: William Weisheit; *St. Anthony Hospital*: Stephen Lowenstein, MD, *UC Medical Student*: Mark Lassise; *Denver Department of Public Health*: John Sbarbaro, MD.

**Robert M. Fitzgerald**

**Division of Socio-Economics/Medical Affairs**

## **AMA Grant to CU Medical School**

A grant of \$14,251.84 has been made to the University of Colorado School of Medicine by the American Medical Association Education and Research Foundation. Funds come largely from direct grants to medical schools and are made directly to the Dean of the medical school without restriction.

## **Physician Health and Rehabilitation Committee Hopes to Obtain Help**

Members with firsthand knowledge of routes to recovery and repair of professional and personal life are sought by the CMS Committee on Physician Health and Rehabilitation. Physician members of Alcoholics Anonymous who share the Committee's desire to assist impaired physicians to confront and overcome problems with alcohol are urged to contact Dr. John Avery in Boulder, telephone 442-4660.

To prepare for its work, Dr. Avery's committee has participated in training conducted by Dr. Thomas Briggs, chairman of the Minnesota state medical society physician health committee, and received advice from Dr. Vern Johnson of the Johnson Institute in Minneapolis. Dr. Briggs set forth procedures for each phase of the work, including verification of a fellow physician's impairment, intervention and encouragement into therapy, and supportive followup.

The understanding which recovering alcoholics can bring to the work, based on their experience with alcohol, will strengthen the effort of the committee. Please contact Dr. Avery if you are willing to make this contribution.

## **Ravin Memorial Dedicated**

The Abe Ravin Division of Cardiovascular Medicine at the Rose Medical Center was dedicated June 25 to the memory of a physician whose accomplishments in the field of cardiology are widely recognized. He is credited with at least 75 medical publications and two books on the subject of cardiovascular disease.

One of the most outstanding achievements was the development of records of simulated heart tones; this record received over one million pressings and was the first medical record to achieve a gold medal in the record industry.

Dr. Ravin, who died February 17, 1978, had pioneered the cardiovascular division at Rose Medical Center which now bears his name.

## **Mitchell Receives Trudeau Medal**

Roger S. Mitchell, MD, former director of the Webb-Waring Lung Institute, and professor emeritus of medicine at the University of Colorado Health Sciences Center has been awarded the Trudeau Medal by the American Lung Association.

The medal annually is presented for "the most meritorious contribution on the cause, prevention, or treatment of lung disease," and honors Edward Livingston Trudeau, MD, first president of the American Lung Association, and founder of the Trudeau Sanatorium, Saranac Lake, New York.

Dr. Mitchell founded the Aspen Lung Conference, and headed the Governor's Task Force on the Health Effects of Air Pollution, and in semi-retirement continues to contribute his time to the Denver Clinic, the Veterans Administration Medical Center, and the Denver Department of Health and Hospitals.



rooms, in company pay envelopes, in billing and statement envelopes, in grocery stores and shopping bags. In addition, Associated Grocers of Colorado has developed a campaign of printing and distribution of these pamphlets in all of their markets across the state, and will be printing and distributing the 'Health Power' message from your Society for the next year. Dillon Stores, owners of the City Market chain of stores on the western slope of Colorado, printed and distributed nearly 40,000 of the pamphlets. Burroughs-Wellcome Company has printed an additional 50,000 of the pamphlets for distribution. "Health Power" is the copyrighted identification of CMS and CMSA, and has also attracted much national attention, where other state societies wish to use the same program.

Colorado Medical Society, in 1978 and 1979, printed and distributed two separate brochures concerning National Health Insurance and government intervention and "information about your doctor," both of which were distributed through physician's offices and clinics. Both presented a well thought-out program of the physician's place in our society, and his importance to our democratic system.

One of these brochures, entitled "Good Health Is Good Living," explained how to save money on medical expenses, why medical costs have increased, and some interesting facts on medical progress.

Public awareness to the physician's concern for safety and health and medical cost containment has been increased by the CMS participation in a petition drive to place the motorcycle helmet law question on the November ballot.

The Colorado Department of Education and Colorado Public Health Association joined Colorado Medical Society and Auxiliary in sponsoring a poster contest in public schools, grade K through 12, throughout Colorado concerning "Health Power" and good health habits. The contest will be conducted again in the fall and winter of 1980.

Colorado Medical Society is, for the first time, sponsoring a statewide media awards program, The Robert L. Perkin Memorial Award for medical reporting. This involves all of the state's newspapers, radio and television stations, encouraging more and better medical reporting.

There are many other projects of promoting public awareness, projects that are on-going, year round. Your ideas and contributions are solicited.

The Communications Office of Colorado Medical Society is always available to assist local component medical societies with public information programs. Ideas for radio interviews, lists of suggested questions on a variety of health topics, hints for contacting medical personnel, all are available to you.

You may write, requesting a listing of these information services, or call with your particular question or suggestion. In Denver, call 861-1221. Outside the metro area, call toll-free, 1-800-332-4150, but call only between 8AM and 5PM, Monday through Friday. The rest of the time this line is dedicated to the use of radio, television and newspaper reporters throughout Colorado, so they can reach the Colorado Medical Society "Medical Hot Line." This is a daily medical news update service which provides your stories to the public media.

## COVER STORY

The Broadmoor Hotel, site of the 1980 Colorado Medical Society Annual Session.

If you've not visited Colorado Springs or the Broadmoor recently, you'll want to take part in this year's Annual Session, not only for the association involvement but for the pleasure of four glorious September days at the Broadmoor.

Steeped in history of the Pikes Peak and Cripple Creek region of Colorado, the Broadmoor has kept pace with the times. The Broadmoor offers year-round golf on championship courses, three outdoor swimming pools fed by heated mountain water, indoor ice skating, curling, hockey, and stellar ice shows in the Broadmoor Arena. There are both outdoor and indoor tennis courts, as well as a host of other athletic facilities and endeavors.

The Broadmoor extends a warm welcome to a choice of award-winning dining and beverage areas, from sophisticated Charles Court, the elegant Penrose Room atop Broadmoor South, and the rustic Tavern, to the oriental richness of the Lake Terrace Lounges and the rollicking Golden Bee English pub.

The Broadmoor way of life also means entertainment, from dancing and listening enjoyment in Spec's Spot, to the handclapping fun and sing-along at the Golden Bee.

Recommended clothing matches Broadmoor's climate and lifestyle. Sportswear is excellent for casual daytime activities, with a light wrap suggested for the cool Colorado evenings of September. After six, gentlemen are required to wear a coat and tie in dining and beverage areas.

Bring the family for a vacation. For family members of all ages, there's plenty of daytime activity nearby. Take the young, middle and older set to Cheyenne Mountain Zoo, one of the world's finest. While you are there, carry a picnic lunch and enjoy one of the numerous outdoor picnic areas on the zoo grounds. If the kids would rather, there's a grill and sandwich bar located at the entrance of the zoo, but beware....it is located ominously near the curio and souvenir stands. While in the zoo, drive up the mountain a short distance to the Will Rogers Shrine and Singing Tower. This is a treat for the entire family. Built on the side of Cheyenne Mountain, this shrine provides an excellent view over all of the Colorado Springs, Broadmoor, Manitou Springs and Air Force Academy area.

Leaving the Broadmoor complex, just a short distance away is the famous "Seven Falls," a treat to see. If you'd like to send the family on a trip while you are involved in business sessions, make reservations for them to travel to the top of Pikes Peak via the cog railway. It's an exciting and a delightful trip. Something less spectacular but a lot of fun is the shorter trip to the top of Mount Manitou cog railway, departing from the same location as the Pikes Peak cog, but only a 45 minute trip up and back. On the north side of Manitou Springs is the world-reknown "Cave of the Winds," which will delight all ages. A little further north is the "Garden of the Gods," one of nature's many wonders. If the family has more time, we suggest a visit to the United States Air Force Academy, a fixture in Colorado for 20 years, but one which few Coloradans have taken the time to see, first-hand.

Yes, there's plenty to see and do in the Colorado Springs, Broadmoor area, and it just might be that mini-vacation you've needed for the entire family.

Please see your JUNE issue of COLORADO MEDICINE for the Broadmoor envelope insert, which will give you room rates for the Broadmoor Main, South and West.



# CONTINUING MEDICAL EDUCATION CALENDAR

PUBLISHED JOINTLY BY THE COLORADO FOUNDATION FOR MEDICAL CARE, COLORADO MEDICAL SOCIETY AND THE COLORADO ACADEMY OF FAMILY PHYSICIANS • 1601 EAST NINETEENTH AVENUE, DENVER, COLORADO 80218

## JULY 1980

### 13th-15th

**HOSPITAL MEDICAL STAFF CONFERENCE AND HOSPITAL TRUSTEE FORUM ADVANCED SEMINAR.** Denver. Contact: Estes Park Institute, P.O. Box 400, Englewood, CO 80151. 761-7709.

### 16th-20th

**SUMMER SKIN SEMINAR.** Aspen. Contact: Office of Postgraduate Medical Education, University of Colorado Health Sciences Center, 4200 E. 9th Ave., Denver, CO 80262. 394-5241.

### 21st-24th

**PRACTICAL GASTROENTEROLOGY FOR THE PRACTICING PHYSICIAN.** Aspen. Contact: Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 E. 9th Ave., C-295, Denver 80262. 394-5241. (15 hours of AMA Category 1 credit).

### 21st-25th

**INTERNATIONAL SYMPOSIUM ON HAND SURGERY — COMPREHENSIVE CARE OF THE DISEASED AND INJURED UPPER EXTREMITY.** Keystone. Contact: John A. Boswick, Jr., M.D., Course Director, 4200 E. 9th Ave., Box C-309, Denver 80262. 394-8718. (22 hours of AMA Category 1 credit).

### 23rd

**COLORADO REGIONAL NEURORADIOLOGY AND COMPUTERIZED TOMOGRAPHY MEETING.** Department of Radiology, University Hospital, Denver. Contact: Leatha Kibel, 394-7773. (3 hours of AMA Category 1 credit).

### 31st-August 3rd

**PEDIATRICS.** Snowmass. Contact: Office of Postgraduate Medical Education, University of Colorado Health Sciences Center, 4200 E. 9th Ave., Denver, CO 80262. 394-5241.

## AUGUST 1980

### 1st-3rd

**COLORADO ACADEMY OF FAMILY PRACTICE ANNUAL MEETING.** The Lodge, Vail. Contact: Shirlee Meyers, 1570 Humbolt St., Denver. 837-0757. (11 prescribed hours of AMA Category 1 credit).

### 2nd-6th

**PATHOLOGY IN OBSTETRICS AND GYNECOLOGY.** Aspen. Contact: Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 E. 9th Ave., C-295, Denver 80262. 394-5241. (28 hours of AMA Category 1 credit).

### 3rd-7th

**PERINATAL MEDICINE.** Snowmass. Contact: Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 E. 9th Ave., C-295, Denver 80262. 394-5241. (21 hours Category 1 credit).

### 6th-9th

**KEYSTONE CONFERENCE ON PARENTING.** Keystone Lodge, Keystone, CO. Contact: Health Education Department, Children's Hospital, 1056 E. 19th, Denver 80218. 861-6847. (15 hours of AMA, AAFP, CNA credit).

### 6th-10th

**DYNAMIC PSYCHOTHERAPY: THE CONCEPT OF COUNTERTRANSFERENCE AND ITS RELATIONSHIP TO PSYCHOTHERAPEUTIC PROCESS.** Aspen. Contact: Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 E. 9th Ave., C-295, Denver 80262. 394-5241. (17 hours of AMA Category 1 credit).

### 11th-15th

**ASPEN CONFERENCE ON PEDIATRIC DISEASE, 1980-LUNG.** The Gant, Aspen. Contact: J. Thomas Stocker, M.D., Department of Pathology, Children's Hospital, 1056 E. 19th Ave., Denver, CO 80218. 861-6712. (25 hours of AMA Category 1 credit).

### 14th

**INFECTIOUS DISEASES.** Denver. Contact: Office of Postgraduate Medical Education, University of Colorado Health Sciences Center, 4200 E. 9th Ave., C-295, Denver 80262. 394-5241.

### 15th-20th

**PRIMARY CARE ORTHOPEDICS.** Aspen. Contact: Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 E. 9th Ave., C-295, Denver 80262. 394-5241. (23 hours of AMA Category 1 credit).

### 20th

**WORKUP OF SUSPECTED AND PROVEN MALIGNANT DISEASES.** Aspen. Contact: Martin J. Rubinowitz, M.D., The Denver Clinic, 701 E. Colfax Ave., Denver 80203. (2 hours of AMA Category 1 credit; 2 prescribed hours of AAFP credit).

### 21st

**ANTICOAGULANTS - WHAT YOU SHOULD KNOW.** Vail. Contact: Martin J. Rubinowitz, M.D., The Denver Clinic, 701 E. Colfax Ave., Denver 80203. (2 hours of AMA Category 1 credit; 2 prescribed hours of AAFP credit).

**27th**

**COLORADO REGIONAL NEURORADIOLOGY AND COMPUTERIZED TOMOGRAPHY MEETING.** Department of Radiology, University Hospital, Denver. Contact: Leatha Kibel. 394-7773. (3 hours of AMA Category 1 credit).

**29th-31st**

**PEDIATRIC NEUROLOGY MINI-COURSE.** Keystone Lodge, Keystone, CO. Contact: Health Education Department, Children's Hospital, 1056 E. 19th, Denver, CO 80218. 861-6947. (10 hours of AMA Category 1 credit).

**SEPTEMBER 1980****4th-5th**

**ADVANCED ARTHROSCOPY SEMINAR.** Writers Manor, Denver. Contact: Health Education Department, Children's Hospital, 1056 E. 19th, Denver, CO 80218. 861-6947. (AMA credit hours available).

**11th-13th**

**OBSTETRICS/GYNECOLOGY FOR FAMILY PHYSICIANS.** Santa Fe, New Mexico. Contact: W. J. Levy, M.D., Symposia de Santa Fe, P.O. Box 5175, Coronado Station, Santa Fe, New Mexico 87502.

**14th-18th**

**HOSPITAL MEDICAL STAFF CONFERENCE AND HOSPITAL TRUSTEE FORUM.** Estes Park. Contact: Estes Park Institute, P.O. Box 400, Englewood, CO 80151. 761-7709.

**15th-18th**

**PULMONARY MEDICINE — 1980: AN UPDATE FOR THE CLINICIAN.** Vail. Contact: Dale E. Braddy, Director of Education, American College of Chest Physicians, 811 Busse Highway, Park Ridge, IL 60068. (20 hours of AMA Category 1 credit).

**21st-24th**

**VASCULAR SURGERY.** Denver. Contact: Office of Postgraduate Medical Education, University of Colorado Health Sciences Center, 4200 E. 9th Ave., C-295, Denver 80262. 394-5241.

**24th**

**COLORADO REGIONAL NEURORADIOLOGY & COMPUTERIZED TOMOGRAPHY MEETING.** Department of Radiology, St. Luke's Hospital, Denver. Contact: Leatha Kibel. 394-7773. (3 hours of AMA Category 1 credit).

**26th-27th**

**9TH ANNUAL MONTROSE FALL CLINICS.** Montrose, CO. Contact: Kathy Holman, Montrose Memorial Hospital, 800 S. Third St., Montrose, CO 81401. 249-2211. (10 hours of AMA Category 1 credit).

**NOTE TO THOSE REGISTERING FOR THE ANNUAL SESSION SCIENTIFIC PROGRAM**

1. There have been some changes in speakers since we went to press.  
Check the August issue of Colorado Medicine for a complete speaker listing.
2. The Friday morning (Sept. 26) UPDATE Scientific Sessions will be in the following order rather than as shown on the printed registration form:

8:00	Diabetes or Antibiotics
9:00	Occlusive vascular disease or Management of the obese patient
10:00	Peptic ulcer management or Pelvic inflammatory disease



# Radiation health effects\*

## *Internal Deposition of Radioactive Materials*

R.W. Bistline, PhD, D.C. Hunt, PhD, and R.E. Yoder, ScD, Golden, Colorado

There are three major routes by which radioactive material becomes deposited within the body of an individual. These routes of entry are inhalation, ingestion, and injection through a cut or penetration in the skin.

### *Inhalation*

The deposition patterns and translocation of inhaled radioactive materials are relatively complicated. Factors such as the aerodynamic particle size of the material, the effectiveness of the natural removal processes in the individual (mucosal and ciliary actions) and the solubility of the materials inhaled are all very influential parameters. Some radioisotopes such as cesium, strontium, iodine, iron, potassium, and tritium are very soluble within the body and are readily solubilized and transported for assimilation by specific organs. Where the material is very insoluble when inhaled, for example plutonium oxide, about 70 to 80 per cent will be removed within the first 24 to 48 hours by the body's natural removal processes in the naso-pharynx and bronchi. Inhalation of such insoluble materials usually leads to enhanced macrophage activity (phagocytosis) within the lungs to remove the remaining foreign materials to the tracheobronchial and bronchial-pulmonary region lymph nodes. The ultimate solubility of the material at this point plays a major role in determining the mean residence time in the lung one might observe and the translocation to other organs of the body or elimination from the body.

The organs to which initially deposited materials are translocated are determined by the chemical nature of the material and the rate of utilization or incorporation of those chemicals by the specific organs. It is probably useful to point out examples of such selectivity by some of the radioisotopes mentioned in the preceding

paragraph. The distribution of cesium and potassium in the body are predominantly associated with the musculature. Strontium is associated with the bones and iodine very specific to the thyroid. On the other hand the distribution of plutonium through inhalation will first be in the lungs and associated lymph nodes<sup>1</sup> and later through very slow translocation with liver and trabecular bone. In some cases of inhalation of very insoluble plutonium, it has taken several years before detectable quantities could be observed in 24-hour urine sample collection. Genetically, most radioisotopes have little concentration in the reproductive organs through the common modes of intake. Therefore, the radiation dose to these organs is usually quite small. Materials such as plutonium have very little affinity for the deposition correlation with organs other than bone, liver, and lymph nodes. Studies show distribution coefficients of only about one atom per million of exposure ultimately translocated to the reproductive organs.<sup>2,3</sup> Even if plutonium were to deposit in small amounts in the gonads, it has been shown by Brooks, *et al.*<sup>4</sup> that the distribution in man is much different from that observed in research animals. In the human organs the distance from the specific loci of deposition in the organ to the spermatagonia is beyond the range of the alpha radiation emitted by the radioisotope.

Extensive animal inhalation research has been carried out by Pacific Northwest Laboratories of Richland, Washington and the Inhalation Toxicology Research Institute, Lovelace Foundation, Albuquerque, New Mexico, using various radionuclides.

### *Ingestion*

Ingestion of radioactive materials has a dynamic similar to that described in inhalation except that the residence time is shorter. The uptake and incorporation of the material is highly dependent upon its solubility as it passes

\* This is the fourth in a series of articles on the health effects of radiation. Presented in this article is a discussion of the health effects in animals and humans as a result of the internal deposition of radioactive materials. ●

through the GI tract. Ingestion can be an important mode of intake for those radioisotopes that are quite soluble and readily incorporated in the food chain.

Probably the most notable example of cancer produced as a result of ingestion of a radioactive material is the population of radium dial painters of the early 1900's. Because of poor safety practices and material control by the workers, ingestion of microcurie quantities of radium occurred which years later caused an increased incidence of bone cancer. Very thorough studies of this population<sup>5</sup> made the major contribution of data used in establishing our present standards for internal deposition of radioisotopes.

The more insoluble elements such as plutonium show only a minor uptake through this pathway.<sup>6</sup> The absorption factor for plutonium through the GI tract is generally accepted to be about  $2 \times 10^{-5}$  for insoluble forms and conservatively  $2 \times 10^{-4}$  if one assumes some polymerization has occurred.<sup>7, 6</sup> Organ deposition of that material which is solubilized through ingestion will be like that described under the inhalation discussion.

### ***Skin Penetration***

Internal radioactive deposition by skin penetration or a cut in the skin will likewise distribute throughout the body, as described under the previous two modes. Here again the solubility is a critical factor in the final distribution pattern. For most elements the skin furnishes a sufficient barrier to prevent internal contamination of any significant or detectable amount unless a penetration of the skin barrier occurs by a puncture, cut, acid burn, or a carrier material such as DMSO. If such a penetration occurs with insoluble plutonium any residual material left at the wound site can serve as a reservoir for very slow translocation.

### ***Discussion***

At the present time most of the internally deposited levels of radionuclides above the known natural background levels occur as a result of medical diagnosis or treatment in which relatively large quantities (millicuries or greater) are administered as the result of professional decisions based on the benefit and risk considerations. A small number of cases from chronic exposure or accidents in industrial

facilities have occurred and are under long term observation.<sup>8, 9</sup> Most of these individuals appear to show no adverse health effects. Studies of the workers involved in the production of nuclear weapons in the 1940's experienced exposure and deposition of insoluble isotopes such as plutonium for as long as 35 years and show no detrimental health effects.<sup>9, 10</sup> Exceptions to this include the uranium miner population where an observed latent increase in lung cancer is now occurring as a result of past inhalation of the radon and radon daughter products in the mine air, the thorotrast patients who were administered thorotrast injections by the medical profession<sup>11</sup> and previously mentioned radium dial painters. In the uranium miners and thorotrast patients where effects have been observed, the levels deposited in the body were very large. Effects on the uranium miners have only been observed where exposures greatly exceeded the present accepted working level standards.

Somatic effects are the only detectable health effects observed to date in human populations which have received high internal depositions of radionuclides. If any somatic effects are seen they usually consist of some type of tumor or cancer in the organ where the primary deposition occurred. Examples of this include the induction of tumors in the lungs of dogs subjected to large dosages of plutonium by inhalation at the Pacific Northwest Laboratories<sup>13</sup> and bone tumors in dogs given intravenous injections of plutonium, radium, thorium, strontium, and americium at the University of Utah.<sup>14</sup>

Questions exist regarding the nonhomogeneity of cell irradiation. This micro dosimetry problem involves the assessment and impact of cell death which does not produce cancer and cell injury (injury or change to the DNA structure) which can cause abnormal cell reproduction. This scientific problem is ameliorated because of the animal and human experience which relates overall health effects to dose.<sup>12</sup>

It should be noted that there may be a great difference in the half life of radionuclides and in the length of time they remain in the body. Some isotopes used in nuclear medicine will rapidly decay and/or be removed from the body in a few hours or days, while others may remain for longer periods up to and including the lifetime of the individual. Because of the concern for health effects from some of those isotopes having long residence times in the body, chelation treatment, such as EDTA and



DTPA, and other means such as lung lavage have been developed to enhance excretion or removal of the materials.

The somatic effects of internally deposited radionuclides appear to increase the potential risk for cancer when exposure is large with respect to established radiation standards. As stated by R.F. Brown of the University of California Medical Center, San Francisco, at lower levels of exposure the cancer relation is unresearchable because observed cancers in the control population are so large with respect to the number of cancers induced by radiation that the radiation effect becomes undetectable.<sup>15</sup> G.W. Beebe stated, "The limitations of the epidemiologic approach to the measurement of human health effects of ionizing radiation discourage any expectations that epidemiologic studies alone will provide the answers... . Epidemiologic studies are observational, not experimental, in nature, and unless we are dealing with large differences and large relative risks, the hazards to inference are consid-

erable. At the very low dose levels that are of the greatest practical concern... the underlying risks may be beyond the resolving power of present epidemiologic methods to measure directly."<sup>15</sup>

## Summary

All living matter has a small quantity of radioactivity within it. In fact, a person receives an annual radiation dose of about 20 mrem from the radiation within his body. It is known that large internal depositions of radioactivity can increase the potential for somatic effects in the form of cancer, but these quantities are large in respect to present standards. The somatic effects of smaller quantities are currently undetectable within the population because of the large observed cancer incidence occurring naturally in the population.

In the next issue Environmental Radiation Concerns will be discussed in perspective.

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board of  
trustees

condensed minutes

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JUNE 20, 1980

1. Adopted policy position re Principles Basic to Effective Delivery of Mental Health Services in Colorado.
2. Denied request for student to attend AMA Student Business Section meeting. Supported sending one housestaff member to the Housestaff meeting prior to the AMA Annual Meeting.
3. Accepted minutes of Council on Socio-Economics and approved motion for CMS staff to contact CFMC to explore working with regional CFMC representatives in monitoring HSA activities.
4. Approved designation of funds allocated by CMS to the Colorado Consortium for Continuing Medical Education as a "grant" with unexpended allocation of 1979-80 funds remaining with the Consortium. Directed Council on Professional Education to examine validity of the Consortium and present a formal report at the next meeting of the Board of Trustees with recommendations and specific problems; report to include poll of areas in the state as to utilization of the Consortium.
5. Directed Executive Committee to arrange for a M.A.I. appraisal of the 1809 E. 18th Avenue and 1824 Williams Street properties, and the Committee to proceed with negotiations with the American Cancer Society.
6. Directed staff to prepare a study in costs for initiation of a cost containment program by the Colorado Medical Society.

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President-elect:	K. Mason Howard, M.D.
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District V:	Robert F. Linnemeyer, M.D.

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(Excused)	District I: David E. Bates, M.D.
	District II: Abraham J. Kauvar, M.D.
	District III: J. Richard Brusenhan, M.D.
	District V: Telford A. Davis, M.D.



## articles

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*James T. Harwood, MD, John B. Moore, MD, and Ernest E. Moore, MD, Denver, Colorado*

## news features

### 284 DRUG INFORMATION FOR THE PHYSICIAN

*by Christopher S. Conner, Pharm.D.*

Colorado physicians needing consultation concerning drugs in an unbiased, up-to-date report now have this resource when and where it is needed in the patient care area.

### 286 CAHME — AN ASSOCIATION FOR MEDICAL EDUCATORS

Colorado Association for Hospital Medical Education, a group of professional medical educators who now can identify major areas of need and provide help to hospital education programs.

### 297 ADVICE FROM THE POLITICIAN (about your involvement in politics).

Jack Warren, MD, Chairman of the CMS Legislative Council, brings back tips from Colorado political candidates on how you can help your cause by helping a particular candidate's cause.

### DMS PUBLISHES FOLDER

Denver Medical Society has made available to its members a handy information booklet concerning "Selected Colorado Health Care Professionals." The booklet provides useful information about several health professional groups and their practice characteristics.

### 287 DEAN OF THE C.U. MED SCHOOL TALKS TO COLORADO MDs.

*University of Colorado School of Medicine Dean interviewed by Ray G. Witham, MD, President, Colorado Medical Society.*

Dr. Witham searches out some of the pieces of the economic puzzle which has befuddled and frustrated state physicians, educators and legislators for years. Such questions as the faculty practice fund accountability, distribution of minorities in the student body and outlook for the future of the school get meaningful answers.

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*Colorado Medicine* (ISSN-0199-7343) is published monthly for \$12 per year by the Colorado Medical Society, 1601 East 19th Avenue, Denver, Colorado, 80218. Second-class postage paid at Denver, Colorado. POSTMASTER: Send address changes to *Colorado Medicine*, 1601 East 19th Avenue, Denver, Colorado 80218.

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# Drug Information For The Physician

One problem constantly facing practicing physicians is the availability of up-to-date, unbiased drug information when and where it is needed in the patient care area.<sup>1</sup> Although many excellent drug information resources are available, most of these are rarely accessible to the practicing physician when drug-related questions arise. Even if resources were available in most hospitals, few physicians have the time to conduct a reasonable literature search on a daily basis.

The majority of physicians polled in the 1974 FDA Drug Information Survey indicated an interest in newer types of drug information sources, one of which was computer and telephone links to a university consultant.<sup>2</sup> In Colorado, a new service is available to practicing physicians which may be one solution to the drug information problem.

The Rocky Mountain Drug Consultation Center (RMDCC) is available to answer any drug-related question from physicians and other health professionals in Colorado. The Center can be reached from 8:00 A.M. - 6:00 P.M. Monday through Friday by calling (303) 893-DRUG. The RMDCC is staffed by clinical pharmacists who are trained to selectively retrieve, evaluate and communicate clinically-relevant information to solve a specific drug-related problem. The Center is located at Denver General Hospital, adjacent to the Rocky Mountain Poison Control Center.

The RMDCC has immediate access to many extensive information resources to adequately handle drug-related questions of any nature, including over 200 textbooks and medical specialties, Index Medicus, MEDLINE/TOXLINE, DRUG-DEX, deHaen Drugs in Use, Iowa Drug Information System and Inpharma.

The Center will respond to any question involving drugs and therapeutics, including adverse drug reactions, drug interactions, drug dosing in renal or hepatic failure, drug therapy of choice, investigational drugs, drug-lab test modifications, drug therapy in pregnancy and the breast feeding period. The RMDCC can provide a response based upon a complete search of the literature within 30 minutes to 1 hour for most questions received. In many cases, the answer is provided directly over the phone when the call is received. In all cases, an oral response is provided

with pertinent documentation from the literature. A written response with reference sources is provided when requested by the physician.

Physicians in Colorado are encouraged to call the RMDCC for their drug therapy questions and patient-specific drug therapy problems. For further information regarding the RMDCC, call Christopher S. Conner, Pharm.D., Director at 893-DRUG.

**Christopher S. Conner, Pharm.D.**  
**Director, Rocky Mountain Drug Consultation Center**

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## new members

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**Denver Medical Society:** Gregory W. Zoller, Francis A. Scott, Michael F. Koszalka, Jr., James R. Alexander, Brian J. Allen, Francis J. Barry, Stephanie A. Gilbert, Douglas B. Carter, James D. Fuchs, Jack V. Norris, Kay Wagner, Robert J. Wester, John P. Woodward, Robert C. Jorden, Paul Resnick, Jerry L. Rubin, Warren Gillette, Terry Grossman, Charles R. Horsburgh, Jr., Stephen D. Thompson, Curtiss J. DuRand, Nancy Germer.

**Arapahoe Medical Society:** Jonathan C. Britell.

**Intermountain Medical Society:** Charles Hart, Robert Gerner.

**El Paso County Medical Society:** Carmel P. Perry, Gerald S. Stein, Alfred M. Wright, Melville S. Lin-scott, Jr.

**Boulder County Medical Society:** James K. Cunningham, James Gregory Rabold, Joseph Robert Montante.

**Larimer County Medical Society:** Michael P. Fangman, Jon T. Lowthian, James L. Michie, Robert W. Burke.

**Mesa County Medical Society:** Mitchell L. Cope-land.



## Continuing Medical Educators' Handbook New Available

A **Continuing Medical Educators' Handbook** has been published as an aid to all those involved in CME who are interested in evaluating and possibly upgrading their own CME programs.

The **Handbook** is a service of the Colorado Consortium for Continuing Medical Education. The Consortium was developed in 1978 to pool the talents and interests of the Colorado Medical Society, the Colorado Foundation for Medical Care, and the University of Colorado School of Medicine, its sponsors.

Contents of the **Handbook** include: Finding Out What Education Is Needed, Choosing the Right Methods for Teaching and Learning, Evaluating the CME Teacher, Evaluating the Effect of an Educational Program on Participants, and Using a Patient Data System to Plan and Evaluate Continuing Medical Education. A listing of CME resources is also included.

To obtain a copy, clip and return the form below.

Yes, I am interested in obtaining \_\_\_\_\_ copy(ies) of the **Continuing Medical Educators' Handbook** at \$9.00 per copy. Enclosed is my check for \$\_\_\_\_\_.

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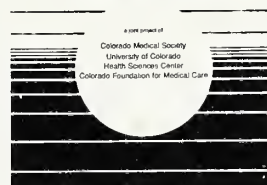
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## CAHME - An association for medical educators

CAHME (Colorado Association for Hospital Medical Education) is an association of professional medical educators from hospitals all around the state. At its planning retreat in November, 1979, CAHME members identified three major areas they felt needed to be explored, and appointed task force committees to research them.

1. The Self-Education/Peer Support Committee: The members decided that one major objective of the association should be self-education; i.e., to use the talent and experiences of its own membership to teach themselves about the processes of medical education. Subsequently, CAHME meetings have become half business/half educational programs, with the result that members with certain areas of expertise have shared their knowledge with their colleagues, helping them to round out their own hospital education programs.

2. Outreach Education Committee: The members agreed that consultation was sometimes necessary for hospitals to improve and enrich their CME programs. It was suggested that CAHME work with the Colorado Consortium for Continuing Medical Education to identify and market the talent (consultants and/or speakers) available through the Association.

3. Political Impact Committee: This committee advised that a clinic should be planned to deal with this topic, and that the politics of hospital medical education should be examined on a regular basis and built into a CAHME action program.

CAHME's 1980 President is N. Kenneth Furlong, Vice President for Medical Affairs at Lutheran Medical Center, Wheat Ridge, 80033. Readers who are interested in joining this association, or who would like additional information about CAHME's goals and guidelines, should contact Dr. Furlong at 425-2010.

## The Pink Sheet - A New Service to Continuing Medical Educators

A new service to Colorado's continuing medical educators is THE PINK SHEET, published bi-monthly by the Colorado Consortium for Continuing Medical Education (CCCME). This is a newsletter which has been developed to give persons involved in continuing medical education highlights of what is going on with CME at the local, state, and national levels.

The May edition included articles on: educational workshops presented jointly by the UCHSC Office of Educational Services and the CCCME; information on how to obtain a speaker on the subject of "Computers and Telecommunications for Colorado's Physicians"; the feasibility of developing interhospital telecommunication via a statewide hospital teleconferencing system; a JCAH program on Quality Assurance; and SDILINE (MEDLINE's current awareness capability).

Persons interested in receiving THE PINK SHEET may call or write: Kevin Bunnell, Executive Director, CCCME, 1601 E. 19th Avenue, Denver, Colorado 80218, 861-1221 x 262 (or 1-800-332-4150 x 262, if outside the Denver metro area).

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## practice management

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The Colorado Industrial Commission recently raised its conversion factors used in the Workmen's Compensation Program. These new factors will begin July 1, 1980. A comparison of 1979 and 1980 factors is shown below:

	1979	1980
Medicine	4.05	4.30
Anesthesia	11.15	11.90
Surgery	39.00	41.70
Radiology	9.50	10.20
Pathology	10.05	10.80
Testimony	\$100.00 per hr.	same

There have been two increases in the two years since your Special Committee for Negotiations began its labors in this arena.



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# president's letter

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*Editor's note: Following is an in-depth interview conducted by Ray G. Witham, MD, President of Colorado Medical Society, with M. Roy Schwartz, MD, Dean of the School of Medicine, University of Colorado. Dr. Witham's purpose in the interview was to clarify some of the aspects of the school's operation on which he had been questioned by CMS members. Dr. Witham has been a staunch supporter of the University of Colorado School of Medicine, but wanted a full expression of the administrative problems of the school and its attempts to mollify the attitudes developed by the press and news media reports. COLORADO MEDICINE is reporting the entire interview, considering that it is a very comprehensive picture of the administrative side to this most important facet of Colorado's medical community. The interview is a result of a request by Dr. Witham. Questions and comments attributed to Dr. Witham are identified by the initial "W:" Dean Schwarz's replies are identified by the initial "S:" If there are details which have been inadvertently omitted in the answers, Dean Schwarz assures COLORADO MEDICINE that he would be most happy to hear from you, personally.*



**W:** Roy, although some may consider this common knowledge, tell us a little of your background and when you arrived at the medical school.

**S:** Well, I'm an MD out of Washington, University of . . . (not Washington University, St. Louis) 1963. I immediately joined the faculty in anatomy there, and spent a year on the faculty before I went to McGill, where I was on the faculty. I left McGill and went to the National Institutes of Health for a very short period of time, and then back to Washington . . . to get away from administration. From there . . . my research interests were in transplantation biology, and I taught gross anatomy and other anatomical discipline. Then, I got interested in the admissions program, and while visiting schools, looking at applicants to medical school, I got the idea of a

four-state medical education program. Between myself and two others we put together that concept. I initiated it, and after nine years when we had phased out of private foundation and federal money and into state, when it was accredited, and when its effects were already being seen, I accepted the job here at Colorado.

**W:** Outside of a nice campus and a beautiful mountain backdrop, what did you find at the school when you arrived last summer? More specifically, describe the state of the faculty practice fund, payment to faculty for care of medically indigent, school's budget, faculty morale and accreditation . . .

**S:** Well, Ray, what I found was the following: As you know, the school gets its money to run from three sources, state grants and contracts, and pro fees that can generate through its faculty practice fund. I found that we were being funded by the state, at the time I arrived, dead last among western medical schools, if you looked at it according to the question of how much money you get from the state toward every resident of that state you admit. We were tied with Utah, but Utah got a big raise last July (July, '79), so we fell dead last. As far as grants and contracts are concerned, I found that the faculty was really doing very well. They, last year, did over probably 29-30-million dollars worth of grants and contracts that placed them . . . in the top ten . . . and it was very surprising, given the little state support that we had, and was even more surprising, with the condition of the faculty practice fund. In that regard, the faculty, for five years prior to my coming, had billed \$61 million worth of gross fees. They'd collected \$29 million at the collection rate of 47 per cent. They committed faculty salaries of \$26 million, so they should have had a \$3 million excess. It turns out they didn't because the state had been appropriating some of the cash in each of those five years, the total amount equaled \$6.6 million, so instead of a \$3 million excess, they'd run up a \$3.6 million deficit with the University treasury, and, in the previous five years, had aggregated a \$600 thousand deficit, so when I arrived the faculty practice fund was \$4.2 million in debt. It had accounts receivable exceeding \$7 million, but they probably weren't worth 30 cents on the dollar, so for all intents and purposes, it was bankrupt.

That \$4.2 million . . . of that, over 2 of it had been accrued in the year just before I arrived, which resulted in a reduction in faculty of 30 to 40, no faculty salary increases last July, and morale, uh, right on the floor. And that was the condition of the school's finances when I got here.

**W:** About the faculty practice fund, just how are the funds distributed, and by whom, Roy?

**S:** Right now, the plan is set up under state statute, and what the statute mandates is you can only use the money for faculty salaries. I can't buy a pencil, piece of paper, book, trip, piece of equipment, can't buy a new chair, can't paint a wall with money from the faculty practice fund. The people sign a contract; they're required to bill through our central services. The money comes back into one budget, and the Dean distributes it to departments to be used for faculty salaries. That's the way it is now. There is . . . there has been, however, over the past year a committee working to revise that fund and to build into it the concept of an individual incentive and a departmental incentive, at the same time supporting the school, as a whole. The way that would work is very similar to the way probably the 85 or 90 similar funds at other medical schools in this country work. And that is that the Dean and the departmental chairman would agree to a base salary for an individual. A piece of that would come from state sources, and the rest from faculty practice income or grants and contracts. Faculty would then see patients, bill the patients; the money would be aggregated but, in this case, under the department's name. Once that faculty member and his colleagues or her colleagues in the department have reached . . . have raised enough money to cover the base of everyone, then we get into what's known as the incentive level. Here, the next dollar that comes in after the base is covered becomes referenced to the individual who earns it. So we've moved from a school orientation to a department, and now to an individual. The first dollar that comes in after the base is covered would be credited to the individual who raised it. He or she would get 45 cents of that dollar, the school would get ten cents and the department would get 45 cents. Under this new plan, the 45 cents to the department or the 10 cents to the school could be used to do the things that we could not, cannot do now, because it would operate as a separate foundation, sort of parallel with the Regents; the Dean would have controlling interest in the foundation, but it would be out from under the control of the present circumstances where we have zero flexibility in its use, other than faculty salaries. That was just voted on by the faculty, and of some 487 votes cast, 87% were in favor of it. It has to now go on up the administrative lines through the Chancellor and the President's offices and on to the Regents, and I don't know what will be the impact. . . . I don't know whether they will accept it or not, but at least it represents an overwhelming majority view by the faculty.

**W:** I think that's a real comprehensive statement about this matter that a lot of the people have been concerned about. Roy, what is the real story behind all this highly-publicized faculty departure, and how has the faculty and the legislature responded to these events?

**S:** Well, Ray, let me answer that in a number of ways: First, if you look at the full-time faculty who resigned in the past academic year, and that starts on July first of '79, through June 30 of '80, and you ask yourself 'what's been the number of people who resigned and how does that compare to previous years?' We had 75 people who had faculty appointments resign. It is the identical number to the previous year, and it's one more than the year before that. So, I don't think, looking at the faculty as a whole, you can make any argument that there was a massive defection and departure of faculty members who were dissatisfied, etc. If you look at that question from the standpoint of Chairmen, we have 22 Chairmen. Of those, we had one resignation which was really forced by the members of the department; we had another resignation which was voluntary on the part of the Chairman of Surgery, and which we did read a lot about; we had one other resignation, which was also voluntary on the part of the Chairman of Anesthesia, who, after he had submitted it verbally to me and the Chancellor and, after it had been accepted decided to change his mind and claim he hadn't done it. We disagreed. He sued us. The Regents removed him as Chairman. He asked to settle out of court. It was settled, but I am not at liberty to discuss details of settlements. Sufficeth to say, it was a very good deal for the University. We saved them a lot of money and got rid of a bad headache. So, if you look at 22 Chairmen, we had one resign under fire from his own faculty and two by uh . . . choice, and the others are all staying put. There was some talk about Barry Pierce. He's decided to stay. Bob Schrier, our Chairman of Medicine, was offered a tremendous opportunity at the University of Washington. He decided to stay, and I don't know exactly why, because they had a lot more in their bag . . . infinitely more than we had to offer him. And so, we have not had a sizeable turnover of Chairmen. We have a search committee going in Surgery. We'll shortly have one going in Anesthesia, and in the third department we're probably going to do a departmental review before we go after a permanent chief there. So, all in all, I think that while the papers wanted to make it appear that the place was falling apart and everybody was leaving, I think the facts speak quite the opposite.



**W:** I want to go back about the search for the Department of Surgery Chairman. We'd like to know what community involvement is in this search, and also what progress is being made at this time?

**S:** That search committee, of which there are about 15 people on it, Ray, chaired by Bob Schrier, has representing the community Hank Cleveland from St. Anthony's, and it also has a Chief of Surgery at Rose Medical Center on it. In essence, there are two people from the community on it. It has basic and clinical scientists on it. It has surgery sub-specialties represented. It has a resident student. It has some affirmative action officer . . . somebody from the hospital. They have put out advertisements, they have solicited CVs; they have reviewed CVs. They found eight external candidates and two internal candidates, I understand, that they were very interested in. Of these external candidates, they've selected five who've been scheduled for visits, and the first visit was just concluded. All the candidates that they have come down on, at least what I've been able to tell, have really been outstanding people, any one of which I think, at least from a paper standpoint, would be a great catch for us. If we're lucky, we'd have somebody in place by January 1, but we might not quite make that.

**W:** If you remember a few months ago, I recommended to the Board of Regents that persons who chair departments at the School of Medicine might well be someone other than a specialist in that particular area of medicine, stressing administrative skills maybe more than academic and practitioner skills, is that any part of your plan in the search committees?

**S:** Part of it is, part of it isn't, Ray. No question you need somebody who has administrative skills to run a department. At the same time you need somebody who has bona fide academic tickets around which faculty can rally in-house staff and students. The compromise that most people have reached on that because, frankly, it's very hard to find (I think in physicians in general but especially among academic physicians,) somebody who has skills not only in patient care, research, teaching, but also administration, you might find a triple-threat but you aren't going to find a quadruple one. And so, the slack is usually made up in the area of administration by hiring a first-class administrative assistant or departmental administrator whose job it is to keep track of budgets, process, who makes certain that the grant applications are done in the appropriate way, who provides the input into the

faculty practice fund, etc. That's the model that I've seen work most effectively, and that is part of our thinking. We have wrestled with this topic at some length, and I would just say for the record that if people have some ideas they'd like to share, I would really be interested, because there are definitely administrative skills, as you know as the President of the Society, that you need to run an organization, whether big or small. The question is how you develop these (skills) in people.

**W:** In another area, there are news stories that have led some of us to think that the University Hospital is one of the weak administrative points in the Health Science Center, particularly in regard to billing procedures. Can you talk to us about what the billing process is and what's been done to try to remedy this apparent weakness?

**S:** It's more than apparent. It is a weakness, and probably the single-most embarrassing issue which we have there. At least every region meeting and almost every party I attend I hear about it. Our billing system is done, in part by the doctors who input information on what they did for the patient, in part by the patient admitting office in the hospital, which gets the vital statistics, etc., and in part by the computer center that runs the computer that spits out the bills and sends them off. Unfortunately, the system doesn't have one single boss, so that errors in one part of the tripartite system may not be known, fully, to the other two partners. People have raised the issue "why is collection rate in your faculty practice fund so low?" All I can say is that it was 42% when I came, and 52% this year. Maybe it will get as high as 55. A number of changes have been made that have not been sweeping. We have not separated the billing of physicians completely from patients. It is a vexing problem for which I do not have an immediate answer. Why is it that we have so much of a problem when other institutions do not? I don't have an answer to that, either, but that's on the agenda for the second year of my tenure.

**W:** Roy, another area of concern, and I've had this concern myself as President of Colorado Medical Society, is that of minority students at the School of Medicine. I have been trying recently to get in touch with minorities and, admittedly, in our own Society we don't have a strong force of minorities. I have concerns about this, and I think the community does, too. We'd like to know what the school is doing in terms of attracting minorities into the classes. We'd like to

know what the per centage of Blacks is in this next freshman class, and whether they are Colorado residents or non-residents, etc.

**S:** Well . . . Colorado, unlike many medical schools, has had for many years a positive posture and a series of programs designed to recruit minority students for medicine. It is probably one of five or six institutions in the country that have really been active in that, and they've done a much better job in that than the place I came from, and I say that with some redness of face because I was the one who should have been responsible for it up there. We have a school-wide committee which is responsible for minority affairs. They have focused almost all of their activity on undergraduate medical students. There are seminars. There are visits to the various campuses. There is counseling, advising, etc. We also have an office of minority affairs which is designed to do, roughly, the same thing, but they are there all the time, versus the faculty committee who aren't. We have an entering class size of 125. This year we have 16 minority students who are entering. 3 are Black; 8 are Hispanic; 3 are Oriental; one is Puerto Rican; one is an American Indian. The three (Black) would probably amount to, oh, somewhere between 2 and 3 percent of the class. We offered positions to additional students, but they chose to go elsewhere. If you look at the house staff for 1980, we have about 41 minorities out of some 660 house staff; that's about 6 per cent. 6 of those are Black, 19 are Hispanic and 19 are Asians. It is interesting that we have about 131 females which represent about 20 per cent of the house staff.

This is going to be a continuing, vexing problem because the pool size, nationally, of minority students who are interested in medicine has plateaued and, in fact, has shown some signs of decreasing. What that means is that the most qualified students are in great demand at a variety of places and can pick and choose where they go. In our case, we have not reached outside of Colorado, say, in the southeast, to recruit students, thinking that the southeast schools should take care of those people and that we ought to be concerned about the minorities in our own state and region. I think that accounts for the higher per centage of Hispanics than Blacks, which is a reflection of the population of the state. My guess is if you look down the road, that coupled with the shrinking pool size and you ask "why is that?" I think in part it is because they can get in the high-paying jobs in multiple other areas where there is a much short-

er training period and much more certainty of financial return. I think, down the road, we're going to see that situation worsening and unless we get into the highschools and colleges and sort of develop our own minor leagues, if you will, to feed us, we're probably not going to see a significant improvement in these per centages.

**W:** Roy, is the school or the admission committee compelled to accept a certain number of Blacks because of federal research funds?

**S:** No. In fact, that's against the federal law. Quotas is what I hear you saying.

**W:** In terms of the rural health needs which I know you're concerned about, we'd like to know about the school's contribution to this. We are aware of and understand the SEARCH program, but we don't know too much about its progress. I know you've been in this area for some time before you came. Tell us a little bit about the status of SEARCH and where it has made any contribution to rural health needs.

**S:** SEARCH, as you know, Ray, is an outgrowth of a desire on the part of the federal government to decentralize the education of health professionals away from health science centers such as ours, putting them out in communities with practitioners for part of their training. You also know I spent about ten years of my life doing that up in the pacific northwest. The difference between what I did up there and the SEARCH program is that SEARCH has been built along the model of what we call an AHEC (Area Health Education Center) of which we have four in this state, roughly in the four corners. There's one in Grand Junction, one up north, in Denver, there's one south on the east side of the range, and there's one down in the Alamosa area. Each has its own community board, advisory board and Director and each desires to have students and residents from the School of Medicine plus other schools go there for their training. It is 2 years old. We are, this coming year, at the height of our federal funding of the program. We just received another \$1.6 million grant. This year you will probably see three to four times as many medical students receiving training out there as any time previously, and I would guess the same number of residents. They'll be out in family medicine, internal medicine, pediatrics, psychiatry and OB, using practicing physicians as their instructors and using the offices and hospitals in the area as sites for training. This is the year of SEARCH. By that I mean this is the year we have to go to the legislature and convince them that



they ought to pick up the budget, as the feds begin to phase out. The feds' view is if the state doesn't want it then it ought to be terminated. If they do want it, then they ought to pick it (the budget) up. Right now, they're putting in some \$300 thousand, and next year we'll probably have to jump that up to \$700 - \$800 thousand, and eventually pick up the whole thing.

**W:** Roy, do you have any idea from this last graduating class how many students indicated an interest in going into primary care?

**S:** Yes, if you include in primary care general medicine plus general pediatrics plus family medicine, it's about half the class, maybe a little more.

**W:** There's been a lot of concern about tuition increases, not only in the medical school, but all over the state. Some of us are not clear on what is going to happen to tuition. We are aware that the legislature moved to enact an increase in all the colleges and universities in the state. Can you give us an idea of what tuitions will be this fall and what increases will be going into effect?

**S:** I just reviewed that because I got from my national body a comparison for next year, and the size tuitions for a resident run from between \$80.00 to \$5,500 per year. Marshall University in West Virginia is low at \$80.00. Penn State University in Pennsylvania is high at fifty-five hundred. In Colorado, the entering student is going to pay \$3,890.00 next year. That places us, probably, in the top ten, and the year after that they are going to pay \$5,500.00, which will place us probably number two. The average . . . is just over a thousand dollars . . . \$1,096.00 . . . so we are clearly three standard deviations off the average, going toward five. If you look at the non-resident tuition, non-residents coming in here, Colorado leads the pack by two and one-half times. Non-resident tuition is \$24,000.00, plus. The next highest state-supported school is \$10,000.00. What that means is that the families of Colorado residents who want to go to medical school are going to have to find ways to pay that large tuition fee. It is driven off the concept that any student attending a Colorado university or school should pay 25% of the cost, and since our costs are some 20-22 thousand a year, the resident ought to pay one-fifth of that, or one-quarter of that, and that's where you get to 55. You say, "well, if it's 22-thousand, why is a non-resident paying \$23,500, or thereabouts?" The answer is

that the legislators think that they ought to make a profit on their investment here, which is a new concept for me, but one they believe in seriously. Therefore, I think it's fair to say, looking at state schools by this time next year, we'll either be at the top in both the resident and non-resident category or number two in the resident category, and I think there's no way that that isn't going to have a discriminatory effect on the poorer people in Colorado. \$5,000.00 a year is a mammoth amount of money. Where are they going to get it? The other side of the coin is: I think that the practicing doctors that graduate from medical schools in this country, and especially Colorado, give back through the course of their career many times over the investment the state makes in their educational process. I mean specifically, but not limited to, provision of care for people who can't pay and for which they don't bill, or for which they do bill and never expect to recover, to say nothing of what they contribute to social agencies, etc. So I am distressed by it, but that is the attitude of our lawmakers and, at least on principal, it is consistent with what they're doing everywhere else in the system.

**W:** I'm curious: what is the percentage of out-state students at the present time.

**S:** I think we, last year, had one out of 125. That was a Wyoming resident, I think.

**W:** This might induce Wyoming to think about a medical school, again.

**S:** Either that or entering into a contract for purchasing slots from us, and paying full cost.

**W:** That's an interesting concept that you've apparently talked with them about.

**S:** Yes, that's the one we had in Washington where Alaska, Montana and Idaho did that.

**W:** What can we do, as physicians in private practice of medicine in Colorado, to support the school, in addition to outright cash contributions, and what can we do to help maintain the University's high standards?

**S:** Well, Ray, you're doing a lot of things already. We have some 3,000 practicing physicians in this state who are on our clinical faculty.

If the state had to pay the bill for the contributions that those people make to the educational program, our budget would be three or four times what it is now. And then, the resident tuition would not be \$5,000.00. It might be as high as \$15,000.00. Maybe it's a good thing we're not paying that part of the bill. Obviously, you can continue that, and intensify it in certain areas, both in teaching and patient care. Many

doctors refer patients to us. We need patients to teach on. If there's a choice of referral between an out of state place and us, I think that's something they could do to help us. Third, they can sure continue to talk a positive image. Fourth, they can support the school of medicine's needs through our legislative programs and requests. If a legislator goes in to have his blood pressure taken and he asks the local doctor: "Do you think our school up there needs more money?" And the doctor says "You bet your boots they do. You know, the salaries of the clinicians are in the 18th percentile, so give them some," that has a tremendous effect on the legislator. I think the other thing, Ray, is that, man . . . if you look at what's happening nationally and in this state, I think it's very clear that those of you in the practicing community and those of us in the academic community have a heck of a lot more to gain by being partners than we do by trying to fight. In fact, if we aren't together, there are those who will push a wedge between us, isolate us and blunt our effectiveness and, in fact, probably make some things happen we really don't want to see happen. So, I think, if the practicing community can help us and teach us how we can help them and how we can incorporate our activities under them, and vice versa, us the same way, I think everybody will profit. I think there's an awful lot you can do that doesn't require money. It just requires good will and attitudes. That's what I'd really like to see.

**W:** I've been in this state for 30 years, and I think we have one of the best climates now to improve those relationships that I've ever seen. The school, of course, is interested in private gifts, and why are private gifts important to a public institution?

**S:** Well, as I mentioned earlier Ray, we get our money from three sources, the state, grants and contracts, which is not public, and I include gifts in that category, and practice income. Only about 20 per cent of our operating budget comes from general fund revenues of the state. The other 80 per cent we make . . . we are private in that sense, and no different than Harvard or Yale or Duke or Stanford. People say to me, "I don't want to support something that the state has a responsibility to." And my answer is 'Don't support the 20 per cent, which is public, and supported by the legislature. Support the 80 per cent which is private, and not supported by the legislature.' Most of the money we get is earmarked. We don't have any flexibility. As you know, the most critically important thing, if you have to show where you have to invest in new ideas, whether it's at student level, resident or

faculty level, is to have a little flexible money that you can use to invest in those ideas and bet on the come. No assurance it'll ever pay off, but it's the investment you make. That's what's most critically needed and that's what we really would appreciate help with at the Center.

**W:** Roy, one last question: What are your plans for the school's future, and what is your vision about where Colorado is going?

**S:** The State of Colorado is obviously in a fantastic position right now. We've got shale. We've got coal. We've got uranium. We've got mountains. We've got streams. We've got wildlife. We're in a part of the country which is very attractive to live in. All that means that there's going to be growth here, diversification, which results in a healthy economy. With this, and with people who have a desire for a first-class school of medicine, and with a large amount of private wealth moving in (private, I mean business and individual), any turndown in the economy which you see in the rest of the country will not be felt anywhere near to the same degree here in Colorado. I think you can see that right now. I certainly project that. Our state budget is going to grow. Our population is going to grow, and with it will come increasing demands on the school. People say we are overbedded in Denver right now, and maybe we are, but the continued population growth is going to take care of that, unless we run off and build a whole bunch of new beds and just continue the problem. As far as the school goes, it's the only one for a thousand miles and, as such, a unique resource and a jewel. I would hope the people of Colorado appreciate that. It is one of the 20 best medical schools in the country; you could, maybe, push me harder than that, but I don't see any reason why we can't eventually, in a few years time, lay claim to the fact that we're one of the five best schools. We can broaden and deepen the resources we've got. We can clean up our show in the areas we have problems, and we can build a unique center which will be a resource and a focus of excellence for this entire rocky mountain region. If we don't, with the resources and population, state budget and private monies, patient needs . . . all those things, if we don't achieve that then there really is something wrong with us because it is sitting right here in front of us. All we have to do is reach out and grab it. A little courage involved, and a little faith; A few things like that but I don't see any reason why it can't be done.

**W:** Thank you, Roy, and I hope the Colorado Medical Society can be a participant in that glowing picture you've painted.



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## REGISTRATION FORMS ON PAGES 7, 9 AND 10

Admission to all events is by Registration Badge Only

## WHO MAY ATTEND

### DOCTORS, STUDENTS AND HOUSESTAFF

All physicians including interns and postgraduate residents are welcome. Non-member physicians will be charged a registration fee of \$25.00. All students of medicine and housestaff are welcome to attend with no registration fee.

### DOCTORS' SPOUSES

They are welcome at all meetings and events.

### ALLIED PROFESSIONS

Dentists, Nurses, Pharmacists and other professional men and women allied with medicine are welcome to register and attend the sessions. Registration fee \$25.00.

### OTHERS

Except for persons indicated above, others may register and attend appropriate parts of the Annual Session only when individually and continually accompanied and sponsored by a member of the Society.

### EDUCATIONAL SESSIONS

The Scientific Session and the Practice Management program are presented by the Council on Professional Education and the Council on Socio-Economics of the Colorado Medical Society and The Office of Postgraduate Medical Education, University of Colorado Health Sciences Center, 4200 East Ninth Avenue, Denver, Colorado 80262.

As an organization accredited for continuing medical education, the University of Colorado Health Sciences Center certifies that this continuing medical education offering meets the criteria for 10 hours in Category 1 of the Physician's Recognition Award of the American Medical Association provided it is used and completed as designed.

### COLORADO MEDICAL SOCIETY OFFICE

### BAILEY-STRATTA ROOMS

Please make your room reservations direct with The Broadmoor by mid-August. Use the advance reservation form in the June issue of *Colorado Medicine*.



**COLORADO MEDICAL SOCIETY AND  
AUXILIARY PROGRAM, SEPTEMBER 23-27**

**TUESDAY, SEPTEMBER 24**

<b>1:30 pm</b>	<b>Finance Committee</b> <i>Sun Room, Golf Club</i>	<b>2:30 pm</b>	<b>Board of Trustees</b> <i>Sun Room, Golf Club</i>
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**WEDNESDAY, SEPTEMBER 24**

<b>8:00 am-</b>	<b>Registration Opens</b> <i>Lobby Level, Broadmoor West</i>	<b>9:00 am</b>	<b>Constitution, By-Laws and Credentials Committee.</b> <i>West Ballroom, Broadmoor West</i>
<b>8:30 am</b>	<b>Colorado Foundation for Medical Care Annual Meeting</b> Introductory remarks by Robert B. Sawyer, MD, Chairman of Board of Directors. Speaker: Eli Ginzberg, PhD, Hepburn Professor Emeritus of Economics, Columbia University, and Director of Conservation of Human Resources Project at Columbia University in New York City. Professor is a noted speaker and author of two recent books entitled, "Limits of Regulations: Search for Realism", 1977, and "Health Manpower and Health Policy", 1978. Question and answer period. Election of Board of Directors <i>Briefing Room, Broadmoor West</i>	<b>9:30 am</b>	<b>House of Delegates First Meeting</b> <i>West Ballroom, Broadmoor West</i>
		<b>12 noon</b>	<b>Reference Committee Chairmen Luncheon</b> <i>Will Rogers Room, Broadmoor West</i>
		<b>12 noon</b>	<b>Grievance Committee Meeting with Component Chairmen</b> <i>Pourtales Room, Broadmoor Main</i>
		<b>1:30 pm</b>	<b>Reference Committee Meetings</b>
		<b>6:00- 7:30 pm</b>	<b>Presidents' Reception</b> Honored guests will be Fifty-year Members and recipients of the Robert L. Perkin Media Awards. <i>West Patio, Broadmoor West</i>
		<b>7:15 pm</b>	<b>CMS Hosted Specialty Society Presidents' Dinner</b> <i>Oval Room, Golf Club</i>

**THURSDAY, SEPTEMBER 25**

<b>7:30 am</b>	<b>Registration Opens</b> <i>Lobby Level, Broadmoor West</i>	<b>8:30 am-</b>	<b>Physician's Learning Center, Scientific Exhibits, Auxiliary Displays</b> <i>West Exhibit Hall</i>
<b>7:30 am</b>	<b>Judicial Council Breakfast Meeting</b> <i>Pike's Peak or Bust Room, Broadmoor West</i>	<b>5:30 pm</b>	
<b>7:30- 9:00 am</b>	<b>COMPAC Breakfast - \$6.75 each</b> Speaker: Paul Lauer, Assistant Director, AMPAC Pre-reservations are urged. See CMS Advance Reservation form, page 292-10. Checks should be made to COMPAC (mark "for breakfast"). <i>Ballroom A and B, Broadmoor West</i>	<b>8:30 am-</b>	<b>Educational Sessions All Day</b> See detailed program pages 292-11 and 292-12
		<b>4:30 pm</b>	
		<b>9:00- 10:00 am</b>	<b>Legislative Educational Session</b> See details, page 292-11
		<b>9:00 am</b>	<b>Physicians' Golf Tournament</b> See details, page 292-8
		<b>9:00 am</b>	<b>Auxiliary Program All Day</b> See detailed program, page 292-6

**Thursday, con't.**

11:00 am	<b>Reference Committee Chairmen Luncheon Meeting</b> <i>Ballroom D, West Ballroom</i>	5:30- 7:00 pm	<b>CMS Reception Hosted by Presbyterian-Saint Luke's Medical Center</b> <i>Lake Terrace Pool</i>
12 noon	<b>CMS Past Presidents' Luncheon</b> By invitation only <i>Pike's Peak or Bust Room, Broadmoor West</i>	7:00 pm	<b>International Buffet and Dance</b> From the Orient via Mexico to Europe. Tickets - \$25.00 each - return reservation form to CMS, see page 292-10 <i>Main Dining Room</i>
1:00 pm	<b>Physicians' Tennis Tournament</b> See details, page 292-8		

**FRIDAY, SEPTEMBER 26**

7:30 am	<b>Registration Opens</b> <i>Lobby Level, Broadmoor West</i>	10:45 am	<b>Coffee Break</b> <i>West Exhibit Hall</i>
7:30 am	<b>Continental Breakfast for Program Participants</b> <i>West Exhibit Hall</i>	11:00 am- noon	<b>Lanning E. Likes Memorial Lecture</b> Detection and Diagnosis of Lung Cancer—Geno Saccomanno, MD <i>Briefing Room, Broadmoor West</i>
7:30- 8:30 am	<b>Prayer Breakfast</b> Spiritual Answers or Today's Traumas—Don Reeverts, Chairman of Denver Leadership Foundation Continental Breakfast Tickets - \$6.00 each - see registration form, page 292-10 <i>Ballroom D, West Ballroom</i>	12 noon	<b>El Paso County Medical Society Caucus Luncheon</b>
8:00- 10:45 am	<b>Scientific Update Programs</b> See page 292-12	12 noon	<b>Denver Medical Society Caucus Luncheon</b> <i>Copper Room, Golf Club</i>
8:30- 10:45 am	<b>Joint CMS and Auxiliary Symposium</b> Physician Families "Family Affairs" Lee Trevithick and Christine Hearth, co-therapists, Larimer County Mental Health Center, Loveland <i>Cheyenne Mountain – Casino Rooms</i>	1:30 pm	<b>Constitution, By-Laws and Credentials Committee</b> <i>West Ballroom</i>
8:30 am- 2:00 pm	<b>Scientific Exhibits, Physicians' Resources Learning Center, Auxiliary Displays, Legislating Medicine</b> <i>West Exhibit Hall</i>	2:00 pm	<b>House of Delegates Second Meeting</b> Election & Installation of Officers <i>West Ballroom</i>
		4:00 pm	<b>ACEP Board of Directors</b> <i>Fountain Area, Main Dining Room</i>
		7:00 pm	<b>ACEP Educational Dinner Meeting</b> <i>Fountain Area, Main Dining Room</i>
		6:30 pm	<b>Colorado Ophthalmological Society</b> Executive and Legislative Committees with KeyMan Team Captains (Dinner meeting) <i>Penrose Room</i>

**SATURDAY, SEPTEMBER 27**

8:30 am	<b>Board of Trustees Reorganization Breakfast Meeting</b> <i>Sun Room, Golf Club</i>
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## HOUSE OF DELEGATES MEETINGS

**WEDNESDAY, SEPTEMBER 24**

9:00 am	<b>Credentials Committee</b> <i>Broadmoor West Ballroom</i>	1:30 pm	<b>Open Reference Committee Hearings—</b>
9:30 am	<b>House of Delegates</b> Address by President Ray G. Witham Address by President-elect K. Mason Howard Address by Dr. Robert B. Hunter, President of the American Medical Association Presentation of Certificates of Service and Robins Award Introduction of Mrs. Harry F. Dvorsky, President-elect of AMA Auxiliary by Mrs. Kathy Thomp- son, President, CMS Auxiliary Address by Roy Schwarz, Dean of University of Colorado School of Medicine <i>Broadmoor West Ballroom</i>		<b>Board of Trustees and Executive Office</b> <i>Ballroom D, West Ballroom</i>
			<b>Constitution, By-Laws and Credentials</b> <i>Academy Room</i>
			<b>Interprofessional Relations</b> <i>Carnation Room</i>
			<b>Legislation</b> <i>Cheyenne Mountain Room</i>
			<b>Medical Service</b> <i>Casino Room</i>
			<b>Professional Education</b> <i>Prohibition Room</i>
12 noon	<b>Reference Committee Chairmen Luncheon</b> <i>Will Rogers Room, Broadmoor West</i>		<b>Public Health</b> <i>White Eagle Room</i>
			<b>Socio-Economics</b> <i>Briefing Room</i>

## THURSDAY, SEPTEMBER 25

11:00 am	<b>Reference Committee Chairmen Luncheon</b> <i>Will Rogers Room, Broadmoor West</i>
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## FRIDAY, SEPTEMBER 26

8:30 am	<b>Reference Committee Reports</b> Packaged and Available to One Representative from Each Component Society	1:00 pm	<b>Credentials Committee</b> <i>Broadmoor West Ballroom</i>
12 noon	<b>Caucus Meetings</b> Denver Medical Society El Paso County Medical Society (Please submit requests for space as soon as possible).	1:30 pm	<b>House of Delegates Reference Committee Reports and Election of Officers and Council Members</b> ----- <b>Installation of new officers</b>

**COLORADO MEDICAL SOCIETY AUXILIARY  
FALL MEETING, SEPTEMBER 24-27, 1980  
THE BROADMOOR**

**Registration:**

Wednesday, September 24, 8:00 a.m. to 4:00 p.m., *Lobby Level, Broadmoor West*

Thursday, September 25, 8:00 a.m. to 4:00 p.m., *Lobby Level, Broadmoor West*  
and 8:30 a.m. to 10:30 a.m., *Golf Club, Mezzanine*

Friday, September 26, 8:00 a.m. to 4:00 p.m., *Lobby Level, Broadmoor West*

**Displays:**

All day Thursday and Friday morning, *West Exhibit Hall*

**WEDNESDAY, SEPTEMBER 24**

- |   |   |
|---|---|
| <p><b>2:00 Auxiliary Tennis Tournament</b><br/>pm Broadmoor Golf Club Tennis Courts<br/>Registration: 1:30 p.m., Tennis Courts<br/>Entry Fee: \$8.00. Play limited to 20.</p> | <p><b>6:00- Presidents' Reception</b><br/>7:30 <i>West Patio, Broadmoor West</i><br/>pm</p> |
|---|---|

**THURSDAY, SEPTEMBER 25**

- |   |   |
|---|---|
| <p><b>7:30 COMPAC Breakfast</b><br/>am <i>Ballroom A and B, Broadmoor West</i><br/>See CMS Advance Registration Form<br/>page 292-10</p> <p><b>9:00 Open Board Meeting</b><br/>am Rolls and Coffee<br/><i>Copper Room, Golf Club</i></p> <p><b>10:15 General Meeting</b><br/>am Keynote Address: Mrs. Harry S.<br/>Dvorsky, AMA Auxiliary President-<br/>elect<br/><i>Copper Room, Golf Club</i></p> <p><b>11:45 Social Hour, Cash Bar</b><br/>am Hostesses: Past State Auxiliary<br/>Presidents (Shuttle from Golf Club<br/>every eight minutes)<br/><i>Ballroom A and B, Broadmoor West</i></p> | <p><b>12:30 Luncheon</b><br/>pm Program and Awards Presentation<br/><i>Ballroom A and B, Broadmoor West</i></p> <p><b>2:30 County Presidents and Presidents-<br/>elect Meeting</b><br/>pm <i>Sun Room, Golf Club</i></p> <p><b>5:30 CMS Reception Hosted by Presbyterian-Saint<br/>Luke's Medical Center</b><br/>pm <i>Lake Terrace Pool</i></p> <p><b>7:00 International Buffet and Dance</b><br/>pm <i>Main Dining Room - \$25.00 each person</i><br/>See CMS Advance Registration Form page<br/>292-10</p> |
|---|---|

**FRIDAY, SEPTEMBER 26**

- |   |  |
|---|--|
| <p><b>7:30- Prayer Breakfast</b><br/>8:30 <i>Ballroom D, West Ballroom</i><br/>am See CMS Advance Registration Form<br/>page 292-10 and program, page 292-4</p> | <p><b>8:30- Joint CMS and Auxiliary Symposium</b><br/>10:45 <b>Physician Families "Family Affairs"</b><br/>am (Some role playing will explore feelings in the<br/>family.) Additional details page 292-4<br/><i>Cheyenne Mountain-Casino Rooms,</i><br/><i>Broadmoor West</i></p> <p><b>11:00</b><br/>am</p> |
|---|--|

**Lanning E. Likes Memorial Lecture**  
Detection and Diagnosis of Lung Cancer  
*Briefing Room, Broadmoor West*  
See CMS Educational Program page 292-12



**COLORADO MEDICAL SOCIETY AUXILIARY  
FALL MEETING ADVANCE REGISTRATION  
September 24-27, 1980**

Name \_\_\_\_\_  
as you wish it to appear on meeting badge      please print

County \_\_\_\_\_

Address \_\_\_\_\_

Position held in State Auxiliary \_\_\_\_\_

Position held in County Auxiliary \_\_\_\_\_

CMS Auxiliary member ☐      Non-CMS Auxiliary member - \$5.00 ☐

Mail to: Mrs. J.R. Salata, 2902 Airport Road #106, Colorado Springs, CO 80910

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**LADIES LUNCHEON**

**Thursday, September 25, 1980**

**12:30 p.m., Ballroom A and B, Broadmoor West**

Cost: \$8.25 per person

Make check payable to Colorado Medical Society Auxiliary. Deadline for reservations is noon (12:00 p.m.), Wednesday, September 24, 1980.

Name \_\_\_\_\_ County \_\_\_\_\_  
please print

Address \_\_\_\_\_

Number of reservations \_\_\_\_\_ Amount enclosed \$ \_\_\_\_\_

Tickets may be picked up at the Ballroom entrance during the Social Hour. Mail reservation and check to: Mrs. J.R. Salata, 2902 Airport Road #106, Colorado Springs, CO 80910

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**AUXILIARY TENNIS TOURNEY REGISTRATION**

**Wednesday, September 24, 1980**

**Golf Club Tennis Courts 2:00 p.m.**

Entry fee: \$8.00

Make check payable to Colorado Medical Society Auxiliary. Play limited to 20 -- pre-registration is recommended.

Name \_\_\_\_\_ County \_\_\_\_\_  
please print

Address \_\_\_\_\_

Number of registrations \_\_\_\_\_ Amount enclosed \$ \_\_\_\_\_

Mail registration and check to: Mrs. Gary Nitz, 5 Westgate Road, Colorado Springs, CO 80906

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### **CMS 1980 SCIENCE FAIR AWARDS**

Senior High Division Winner — Phillip B. Danielson, Denver  
"Atherosclerosis As Related to Blood Coagulation; Blood Pressure Altered Aerobic; Isometric Exercise"

Junior High Division Winner — Lorna Virgil, Akron  
"What Causes Small Children to Be Attracted to Poisons"

Lorna's display will be set up in the West Exhibit Hall on Friday, September 26 until 2:00 p.m.

Phillip will present a slide program from his display on Friday, September 26 until 2:00 p.m.  
(His display was destroyed while being shipped back to Denver from the National Science Fair.)

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Scientific Exhibits, Physicians' Learning Resource Center and Auxiliary Displays will be set up in the West Exhibit Hall all day Thursday and until 2:00 p.m. Friday. Coffee breaks during the educational programs will be in the West Exhibit Hall.

On Friday the CMS Council on Legislation will meet informally with legislative keymen from component societies to discuss 'Legislating Medicine'. Anyone interested in the legislative process of the Colorado Medical Society is invited to come to the West Exhibit Hall on Friday to discuss this important subject.

### **ANNUAL COLORADO MEDICAL SOCIETY TENNIS TOURNAMENT**

One half day of play, Thursday afternoon, September 25. Play will be between 1:00 and 5:00 p.m. Registration fee: \$7.50. - does **not** include court fee. (\$8.00 an hour for singles; \$10.00 an hour for doubles). A drawing will take place beginning at 8:30 a.m. for those of you who have not pre-arranged for a partner. You must be pre-registered and must be present at the drawing. Play will be between players of equal level.

Two-level Competition: A Level - consistent players  
B Level - average players

### **THIRTEENTH COLORADO M.D. INVITATIONAL GOLF TOURNAMENT**

Sign up at the Society's Registration Desk - Broadmoor West Lobby.

Entry Fee: \$20.00 per person - does **not** include green fee - \$16.00, or cart for two - \$14.00.

Play will be on the East Course.

One day of play, Thursday, September 25. Since many players do not have established handicaps, play will be on the Calloway System. There will be recognition for low gross scores. Starting times have been reserved on the Course from 9:00 a.m. to 11:00 a.m. Play is to be in foursomes arranged by contestants.

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**Your check made payable to the Colorado Medical Society should reach the Society in Denver by September 18. Return advance registration forms for golf and tennis.**



**(see other side to register for golf, tennis, banquet, prayer breakfast and COMPAC breakfast)**

Name \_\_\_\_\_ Degree \_\_\_\_\_  
 please print!  
 Address \_\_\_\_\_  
 Phone \_\_\_\_\_

Irene E. Hobart  
Colorado Medical Society  
1601 E. 19th Avenue  
Denver, CO 80218

<input type="checkbox"/> 8:30 a.m. to 11:30 a.m. ATHEROSCLEROSIS	OR	<input type="checkbox"/> 8:30 a.m. to 11:30 a.m. INFECTIONS
<input type="checkbox"/> 12:30 p.m. to 4:30 p.m. PRACTICE MANAGEMENT Program begins at 12:30 with a luncheon presentation. *\$10.00 per person	OR	<input type="checkbox"/> 1:30 p.m. to 4:30 p.m. COMPUTERS FOR COLORADO'S PHYSICIANS

☐ Pelvic Inflammatory Disease      OR      ☐ Joint CMS and Auxiliary  
OR      Symposium —  
☐ Antibiotics      Family Affairs  
(non-accredited)

☐ Occlusive Vascular Disease

OR

☐ Management of the Obese Patient  
by the Primary Physician

☐ Peptic Ulcer Management

OR

☐ Diabetes Mellitus

□  
Lanning E. Likes Memorial Lecture  
Detection and Diagnosis of Lung Cancer

292-9

**CMS REGISTRATION FORM FOR SEPTEMBER 24-27, 1980 ANNUAL SESSION**

Please be sure your name, address and phone number are on the reverse of this page.

**REGISTRATION FOR NON-EDUCATIONAL EVENTS**

☐ **Thirteenth Colorado Physicians' Invitational Golf Tournament - September 25**  
9:00 a.m.-5:00 p.m.

Name \_\_\_\_\_  
please print

Address \_\_\_\_\_

Partner \_\_\_\_\_

Entry fee: \$20.00 per person - does not include greens fee (\$16.00 per person), nor golf cart (\$14.00 for two people). See information included in this program.

☐ **Annual Colorado Medical Society Physicians' Tennis Tournament - September 25**

One-half day of play - Thursday afternoon, 1:00 p.m.

Name \_\_\_\_\_  
please print

Address \_\_\_\_\_

Partner \_\_\_\_\_

Registration fee \$7.50 Check must be received by September 18th.

Indicate level of competition: A LEVEL (consistent players) ☐  
B LEVEL (average players) ☐

☐ **Colorado Medical Society International Buffet - September 25 - 7:00 p.m.**

Name \_\_\_\_\_  
please print

Address \_\_\_\_\_

Banquet is \$25.00 per person Reserve \_\_\_\_\_ (#) tickets

☐ **Prayer Breakfast - September 26** \$6.00 per person 7:30 a.m.

**Total Enclosed (for educational programs and non-educational events) \$\_\_\_\_\_**

Please make check payable to the Colorado Medical Society. Mail this form and your check to:  
Irene E. Hobart  
Colorado Medical Society  
1601 E. 19th Avenue  
Denver, Colorado 80218

**COMPAC Breakfast - September 26** \$6.75 per person 7:30 a.m.

Please make check payable to COMPAC (mark "for breakfast").  
Mail this form and separate check to Irene Hobart as indicated above.



## CMS EDUCATIONAL PROGRAM

THURSDAY, SEPTEMBER 25

Two major topics will be treated in depth during concurrent sessions

### 8:30 am-12 noon **I. Atherosclerosis**

#### **Part A. Pathogenesis - A Telelecture**

Presentation (speakers will participate from their home communities)

Moderator: Elmer Koneman, Executive Director, Colorado Association for Continuing Medical Laboratory Education

#### **The Morphology of the Plaque**

Jack C. Geer, MD, Chairman, Department of Pathology, University of Alabama, Birmingham

#### **Genesis of the Plaque**

Roger Hamstra, MD, Associate Professor of Medicine, University of Colorado School of Medicine

#### **Systemic Causes: General Risk Factors**

William Insull, MD, Methodist Hospital, Houston, Texas

This portion of the program will be done via Tele-Net (telelecture), and will involve all speakers, the participants at The Broadmoor, and participants at other Tele-Net locations around the state. The Colorado Medical Society gratefully acknowledges contributions toward this portion of the program from CIBA Pharmaceutical Co.

#### **Part B. Diagnosis of Atherosclerosis**

Coronary arteriography, nuclear cardiac scanning and other diagnostic modalities in diagnosing atherosclerotic cardiovascular disease.

Wayne Wenzel, MD, Radiologist, Presbyterian Medical Center, Denver

Howard P. Horsley, Jr., MD, Cardiologist, St. Joseph Hospital, Denver

Joseph Rainwater, MD, Cardiologist/Radiologist, Denver  
*Cheyenne Mountain & Casino Rooms*

### **II. Infections**

#### **Herpes Virus - A Real Pain**

James A. McGregor, MD, Denver

#### **Prophylactic Antibiotic Usage and the High Incidence of Nosocomial Infections and How To Prevent Them**

Robert L. Cox, MD, Denver

#### **Hepatitis**

John Vierling, MD, Gastroenterologist, Denver VA Hospital and University of Colorado School of Medicine

The Colorado Medical Society gratefully acknowledges contributions toward this portion of the program from The Purdue Frederick Company and E.R. Squibb and Sons, Inc.  
*Carnation and Academy Rooms*

9:00-10:00 am

#### **Legislative Educational Session**

for both active and prospective key contacts. Come learn how to influence your legislator in an effective, successful manner!

*El Pomar Room*

12:30-4:30 pm	<b>Practice Management</b>	3:15-3:30 pm	<b>Break</b>
12:30 pm	<b>Lunch</b> (advance registration \$10.00 per person)	3:30-4:30 pm	<b>The Plaintiff's Attorney: His View of Your Case</b> Frank Plaut, JD, Practicing Attorney, Lakewood, Colorado <i>West Ballroom D</i>
1:00-2:00	<b>Long Range Financial Planning</b> Dr. Craig T. Callahan, Professor of Finance; Dr. C. Thomas Howard, Professor of Finance, Graduate School of Business and Public Management, University of Denver	1:30-5:00 pm	<b>Computers for Colorado's Physicians</b> A presentation on computers and telecommunications systems that physicians can use in their own practices. <b>Overview</b> - Kevin Bunnell, EdD, Colorado Medical Society
2:00-2:15 pm	<b>Break</b>		
2:15-3:15 pm	<b>Health Insurance in the '80's - Physician Participation</b> Panel Presentation Chris Chandler, Vice President and General Counsel, Western Farm Bureau Life Insurance Company, Legislative Liaison for Health Insurance Association of America M. Earl Rideout, Vice President, Private Business Division, Blue Cross/Blue Shield of Colorado John Isham, Director of Medicare Program, Health Care Financing Administration Frank L. Hays, Jr., Esq., Lobbyist for Health Insurors, Alcohol Industry Physician - to be announced		<b>Ambulatory Practice Systems</b> Jan Baumgardner, MD, Medical Director, Storage Technology Corporation, Lafayette Larry Green, MD, CEIS, Family Medicine Information System, Denver  <b>A Clinical Information System</b> David Steinman, MD, Williams Family Practice Center, University of Colorado Health Sciences Center, Denver  <b>A Working Hospital System</b> N. Kenneth Furlong, MD, Lutheran Hospital, Denver <i>Briefing Room</i>

#### FRIDAY, SEPTEMBER 26

8:00-10:45 am	Two sessions to run concurrently		<b>Peptic Ulcer Management</b> Jack Struthers, MD <b>Diabetes Mellitus</b> Robert "Nick" Alsever, MD The Colorado Medical Society gratefully acknowledges a contribution from Pfizer Laboratories in support of this presentation.
	<b>Pelvic Inflammatory Disease</b> James A. McGregor, MD <b>Antibiotics</b> Robert L. Cox, MD		<b>Joint CMS and Auxiliary Symposium</b> "Family Affairs" (non-credit) <i>Cheyenne Mountain &amp; Casino Room</i>
	<b>Occlusive Vascular Disease</b> W. Gerald Rainer, MD <b>Management of the Obese Patient by the Primary Physician</b> Robert "Nick" Alsever, MD and Nancy Mohler, RD	8:30-10:45 am	<b>Lanning E. Likes Memorial Lecture</b> Detection and Diagnosis of Lung Cancer - Geno Saccomanno, MD <i>Briefing Room, Broadmoor West</i>

We wish to express our thanks to the A.H. Robins Company for its financial contribution to the Society's Annual Session.





### **LANNING E. LIKES MEMORIAL FUND**

#### **Dr. Likes**

The Lanning E. Likes Memorial Fund was created by Dr. Likes' will in 1967 for the purpose of funding eminent cancer specialists to speak at Colorado Medical Society educational programs. The fund is used to provide the resources to bring in speakers who are experts in the detection and/or treatment of any type of cancer.

Dr. Likes was born in Des Moines, Iowa in November, 1888. After graduating from the University of Colorado in 1912, he interned at St. Joseph Hospital in Denver. His private practice in Lamar was interrupted by Army service in World War I. He served as a surgeon at Mon Pont, France.

In 1936, Dr. Likes attended the University of Vienna, received a Masters degree in Surgery from the University, then spent five months in post graduate surgery in Paris and London.

He and his first wife, Margaret, had two children, Elizabeth and Edwin. Elizabeth Likes Husted and her husband live in Boulder. Edwin continues the Lamar practice he shared with his father since the end of World War II. Dr. Likes' first wife died in 1950, and in 1952 he married Leone Swanson. Dr. Likes' children gave him six grandchildren.

He was a member of many civic organizations, served on the State Board of Health, as well as several Colorado Medical Society committees, including the Cancer Committee from 1960-1965. His interest in cancer spanned many years. He was a member of the Colorado division of the American Cancer Society, serving as President 1959-1961. In 1964 he received the American Cancer Society's National Distinguished Service Award and an honorary life membership in the ACS.

Lanning Likes passed away in 1968. He is remembered by those who knew and worked with him and by other Colorado physicians who have benefited from the educational programs provided by the trust fund established in his name.

## FIFTY-YEAR PHYSICIANS

THE COLORADO MEDICAL SOCIETY EXTENDS SINCERE CONGRATULATIONS TO THE FOLLOWING PHYSICIANS WHO RECEIVED THEIR MEDICAL DEGREES IN 1930, THEREBY BECOMING MEMBERS OF THE FIFTY-YEAR CLUB IN 1980.

### DENVER MEDICAL SOCIETY

LEWIS BARBATO, MD  
ROBERT STERLING, MD  
FRANKLIN P. WHERRY, MD  
GEORGE WOLLGAST, MD

### EL PASO COUNTY MEDICAL SOCIETY

A CAMPBELL DENMAN, MD

### PUEBLO COUNTY MEDICAL SOCIETY

GRANT R. CURLESS, MD

### WELD COUNTY MEDICAL SOCIETY

TRACY D. PEPPERS, MD  
JOHN A. WEAVER, JR., MD

### LIVING PAST PRESIDENTS OF THE COLORADO MEDICAL SOCIETY

Fred A. Humphrey, MD - 1949  
Samuel P. Newman, MD - 1952  
Robert T. Porter, MD - 1955  
George R. Buck, MD - 1956  
Gatewood W. Anderson, MD - 1957  
Cyrus W. Anderson, MD - 1960  
Bradford Murphey, MD - 1962  
Samuel B. Childs, MD - 1964

John M. Wood, MD - 1969  
Marvin E. Johnson, MD - 1970  
Kenneth A. Platt, MD - 1971  
Kenneth A. Kahn, MD - 1973  
Joseph S. Pollard, MD - 1975  
William S. Curtis, MD - 1977  
Robert B. Sawyer, MD - 1978



**COUNCILS AND COMMITTEES PLANNING  
THE ANNUAL SESSION**

**ANNUAL SESSION  
COORDINATING COMMITTEE**

Ray G. Witham, MD, Chairman  
Richard F. Bedell, MD  
K. Mason Howard, MD  
Terrance E. Kelly, MD  
Patrick G. Moran, MD  
John F. Mueller, MD  
Theodore R. Sadler, Jr., MD  
Mrs. Kathy Thompson - Auxiliary

**ANNUAL SESSION EDUCATIONAL  
PROGRAM PLANNING COMMITTEE**

Patrick G. Moran, MD, Chairman  
Terrance E. Kelly, MD, Co-Chairman  
John M. Connolly, MD  
Dean L. Girard, MD  
M. Ray Painter, MD  
W. Gerald Rainer, MD  
David Steinman, MD  
Rachelle Kaye, PhD  
Mrs. Kathy Thompson - Auxiliary  
Mrs. Joyce Sowl - Auxiliary

**COUNCIL ON LEGISLATION**

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Charles A. Dafoe, MD  
David L. Edwards, MD  
Daniel J. Greenholz, DO  
Jack A. Klapper, MD  
H.R. Safford, III, MD  
James M. Woodward, Jr., MD

**COUNCIL ON PROFESSIONAL EDUCATION**

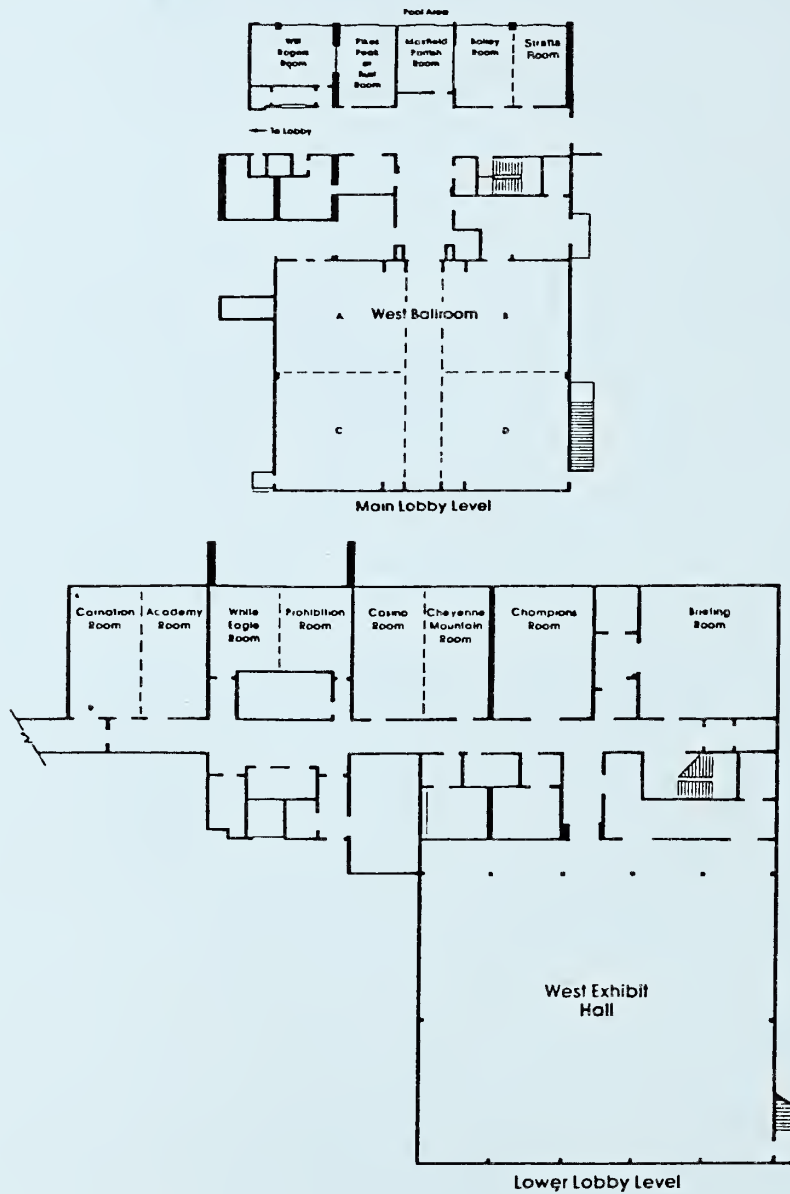
John F. Mueller, MD, Chairman  
Carl E. Bartecchi, MD  
N. Kenneth Furlong, MD  
Abraham J. Kauvar, MD  
Harry R. Locke, MD  
Patrick G. Moran, MD  
Franklin D. Yoder, MD

**COUNCIL ON SOCIO-ECONOMICS**

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Wesley W. Boucher, MD  
Lynn F. Greenlee, MD  
Fred. B. Groves, MD  
J. Cuthbert Owens, MD  
Kenneth C. Sawyer, MD  
A. Glenn Shoptaugh, MD

# CMS ANNUAL SESSION

## The Broadmoor West





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# board of trustees condensed minutes

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JULY 16, 1980

1. Endorsed the second annual Colorado Physicians Run for 1980.
2. Directed the Organizational Study Committee the task of determining how Reference Committees will be constituted and maintained.
3. Approved Travel Policy for AMA Interim and Annual Meetings.
4. Approved Council on Legislation proposal to sponsor an educational session for KeyMen at the Annual Session; component societies to identify individuals interested in becoming active in legislative activities.
5. Approved resolution for submission to House of Delegates, "Financial Support for Medical School from Colorado Medical Society Membership."
6. Approved recommendations of the Executive Committee to: (a) Ratify professional liability insurance contract with The Hartford; (b) Contract with broker on a cost-plus basis; (c) Modify charge to Risk Management Committee; (4) Retain V. O. Schinnerer, and Company, Inc., subsidiary of Marsh/McLennan, to do a professional liability insurance feasibility study.

MEMBERS PRESENT: President: Ray G. Witham, M.D.  
President-elect: K. Mason Howard, M.D.  
District I: David E. Bates, M.D., Merlin G. Otteman, M.D.  
District II: Jerry J. Appelbaum, M.D., Frederick A. Lewis, Jr., M.D., Philip H. Norton, M.D., Wilfred Stedman, M.D.  
District III: J. Richard Brusenhan, M.D., Amilu S. Martin, M.D.  
District IV: Jan S. Hildebrand, M.D., Hanns C. Schwyzer, M.D.  
District V: Telford A. Davis, M.D.

MEMBERS ABSENT: District II: William E. Jobe, M.D., Abraham J. Kauvar, M.D., Joseph H. Poynter, M.D.  
District V: Robert F. Linnemeyer, M.D.

## YELLOW PAGES LISTINGS

Solicitation for listings in the Yellow Pages of the Mountain Bell Telephone books varies depending on your location. The Judicial Council affirms previous opinions that in order to maintain consistency, listings in the Yellow Pages should follow the list of designated specialty codes from the AMA. In addition a physician may list in his primary specialty and in any sub-specialty for which the physician feels himself qualified. The Council concluded that physicians should be allowed to maintain an ethical listing in any Colorado Yellow Pages directory from which they wish to draw patients or the region which they serve.

# CONTINUING MEDICAL EDUCATION CALENDAR

PUBLISHED JOINTLY BY THE COLORADO FOUNDATION FOR MEDICAL CARE, COLORADO MEDICAL SOCIETY AND THE COLORADO ACADEMY OF FAMILY PHYSICIANS • 1601 EAST NINETEENTH AVENUE, DENVER, COLORADO 80218

## AUGUST 1980

### 11th-15th

**ASPEN CONFERENCE ON PEDIATRIC DISEASE, 1980-LUNG.** The Gant, Aspen. Contact: J. Thomas Stocker, M.D., Department of Pathology, Children's Hospital, 1056 E. 19th Ave., Denver, CO 80218. 861-6712(25 hours of AMA Category 1 credit).

### 14th

**INFECTIOUS DISEASES.** Denver. Contact: Office of Postgraduate Medical Education, University of Colorado Health Sciences Center, 4200 E. 9th Ave., C-295, Denver 80262. 394-5241.

### 15th-20th

**PRIMARY CARE ORTHOPEDICA.** Aspen. Contact: Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 E. 9th Ave., C-295, Denver 80262. 394-5241. (23 hours of AMA Category 1 credit).

### 20th

**WORKUP OF SUSPECTED AND PROVEN MALIGNANT DISEASES.** Aspen. Contact: Martin J. Rubinitz, M.D., The Denver Clinic, 701 E. Colfax Ave., Denver 80203. (2 hours of AMA Category 1 credit; 2 prescribed hours of AAFP credit).

### 21st

**ANTICOAGULANTS - WHAT YOU SHOULD KNOW.** Vail. Contact: Martin J. Rubinitz, M.D., The Denver Clinic, 701 E. Colfax Ave., Denver 80203. (2 hours of AMA Category 1 credit; 2 prescribed hours of AAFP credit).

### 27th

**COLORADO REGIONAL NEURORADIOLOGY AND COMPUTERIZED TOMOGRAPHY MEETING.** Department of Radiology, University Hospital, Denver. Contact: Leatha Kibel, 394-7773. (3 hours of AMA Category 1 credit).

### 28th-30th

**28th ANNUAL JAMES J. WARING CHEST CONFERENCE.** Estes Park, CO. Contact: American Lung Association of Colorado, 1600 Race Street, Denver, CO 80206. 388-4327. (10 hours of AMA Category 1 credit).

### 29th-31st

**PEDIATRIC NEUROLOGY MINI-COURSE.** Keystone Lodge, Keystone, CO. Contact: Health Education Department, Children's Hospital, 1056 E. 19th, Denver, CO 80218. 861-6947. (10 hours of AMA Category 1 credit).

## SEPTEMBER 1980

### 4th-5th

**ADVANCED ARTHROSCOPY SEMINAR.** Writers Manor, Denver. Contact: Health Education Department, Children's Hospital, 1056 E. 19th, Denver, CO 80218. 861-6947. (AMA credit hours available).

### 5th

**SURGERY OF ADRENAL TUMORS.** Birch Room, St. Anthony's Hospital, 4231 W. 16th Ave., Denver. Contact: Carol Moen. 629-3678. (1 hour of AMA Category 1 credit).

### 11th-13th

**OBSTETRICS/GYNECOLOGY FOR FAMILY PHYSICIANS.** Santa Fe, New Mexico. Contact: W. J. Levy, M.D., Symposia de Santa Fe, P.O. Box 5175, Coronado Station, Santa Fe, New Mexico 87502.

### 14th-18th

**HOSPITAL MEDICAL STAFF CONFERENCE AND HOSPITAL TRUSTEE FORUM.** Estes Park. Contact: Estes Park Institute, P.O. Box 400, Englewood, CO 80151. 761-7709.

### 15th-18th

**PULMONARY MEDICINE - 1980: AN UPDATE FOR THE CLINICIAN.** Vail. Contact: Dale E. Braddy, Director of Education, American College of Chest Physicians, 811 Busse Highway, Park Ridge, IL 60068. (20 hours of AMA Category 1 credit).

### 21st-24th

**VASCULAR SURGERY.** Denver. Contact: Office of Postgraduate Medical Education, University of Colorado Health Sciences Center, 4200 E. 9th Ave., C-295, Denver 80262. 394-5241.

### 24th

**COLORADO REGIONAL NEURORADIOLOGY & COMPUTERIZED TOMOGRAPHY MEETING.** Department of Radiology, St. Luke's Hospital, Denver. Contact: Leatha Kibel, 394-7773. (3 hours of AMA Category 1 credit).

### 26th-27th

**9th ANNUAL MONTROSE FALL CLINICS.** Montrose, CO. Contact: Kathy Holman, Montrose Memorial Hospital, 800 S. Third St., Montrose, CO 81401. 249-2211. (10 hours of AMA Category 1 credit).

### 27th

**CARDIOLOGY: DIAGNOSIS & SURGERY.** The Broadmoor, Colorado Springs. Contact: Barbara Porter, American Association of Medical Assistants, 6825 Cliff Palace, Colorado Springs, Colorado 80911. (6 hours CEU).



## Mental Health Position

The interim study committees of the Colorado Legislature have been in session. Two of them have among their topics for discussion the mental health program for the state.

It was in anticipation of this study and recognition by the state that certain problems exist with the program that the Denver Medical Society's Special Committee on Mental Health directed its position paper, which was completed this summer. This document, along with the background material accompanying it and the recommendations it contains for reorganizing the mental health program has been adopted by both the Denver Medical Society and the Board of the Colorado Medical Society. The two will thereby be working in concert on the state and on the local level in efforts to resolve the issues.

Three of the needs discussed in the report are:

1. More involvement of physicians in the treatment programs developed for individual patients.
2. Designation of a central authority to exercise some measure of control over the components of the program.
3. The provision of funding to make possible additional long-term institutional care which certain patients obviously still require.

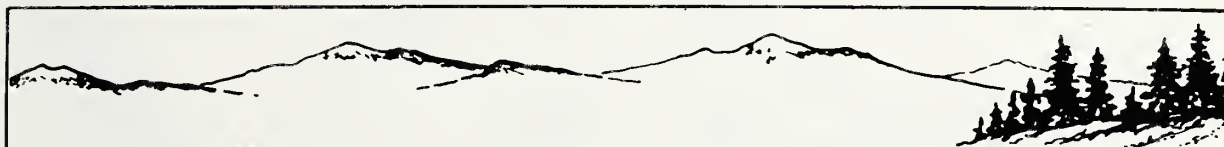
## DMS Publishes Folder

A 12-page folder outlining the practice characteristics of "Selected Colorado Health Care Professionals", prepared by the Interprofessional Conference Committee of the Denver Medical Society, has been published in culmination of a several-year effort by the committee.

Each group represented has ordered copies for distribution to its members. DMS has mailed the folder to its members.

A definition of each discipline, plus the educational requirements, scope of practice, licensure requirements and listing of the local and national association representing them is given for the following professionals: doctors of medicine, doctors of osteopathic medicine, dentists, podiatric physicians, psychologists, pharmacists, registered nurses, optometrists, child health associates and social workers in health care.

A few extra copies are available. If a physician is interested in receiving one, send a request to the Denver Medical Society, 1601 E. 19th Avenue, Denver 80218.



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## Advice From The Politicians

*"You should pick a candidate you can support, then ACTIVELY support his/her election. You can give money, but more tangible help is of greater value. For example: walk blocks with your candidate; make phone calls or stuff mailers for him."*

This was the advice given by the legislators who attended the CMS third Legislative Seminar this past Memorial Day weekend at Vail. Colorado Medical Society members were told that their ability to favorably influence legislation would increase many times as a result.

There are alternative routes leading toward influence on medical legislation: among them is your membership in COMPAC. You will find that your COMPAC membership is helpful in supporting those candidates whose philosophy is most favorable to medicine. Nothing is more gratifying than grass roots politics, EXCEPT for your direct, personal involvement in a campaign. It is, however, not as simple as this advice implies.

No one should assume that a person's involvement in a campaign assures that person of influence on an elected official. Few of us would be so cynical as to help in a campaign motivated solely by this self-interest.

The real reason a person can develop some influence on the political system is because that person has personally helped with a candidate's campaign, thereby learning how the system works. This knowledge allows the person to be more effective, to provide information to the right people, to avoid doing what might be misunderstood as "applying pressure out of self-interest motives." I would not have you become involved in your candidate's campaign because you took our legislator's advice literally. The political system is much too complicated to operate so simply. That is just one of the reasons Colorado Medical Society employs a full-time lobbyist.

The CMS view of lobbying is best understood in the perspective of education: from this view, lobbying is providing resource information to those legislators in order that they may understand the "right" legislative position. The "right" position is, of course, for the benefit of our patients, the public.

So, you should become involved in grass roots politics. It will give you a greatly expanded appreciation of this fascinating, complicated process. It will allow you an opportunity to help those who need straightforward, useful information, keeping the welfare of our patients in mind. It will allow you to learn so much more about a field in which we all should be expert: the health

care delivery field. It will allow you a different appreciation for democracy in action: the need for compromise and the demand for knowledge about the other fellow's viewpoint.

Now . . . get involved! Find a candidate you can support. Support your candidate actively. Know that this support will make your community a better place to live. Rest assured that your valuable help to your candidate will make you an important source of medical information for your candidate. A great number of these good people, willing to spend so much time and energy for the good of their community, do sorely need reliable sources of information about health matters.

**Jack Warren, MD, Chairman,  
CMS Council on Legislation**

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# obituaries

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Doctor **Nathan Samuel Shumsky** died May 29, 1980 at the age of 71.

Doctor Shumsky was born July 5, 1908 in Denver, and attended Fairview and Cheltenham elementary schools, and North High School in Denver before attending the University of Denver from which he proceeded to the University of Colorado School of Medicine, from which he was graduated in 1932.

He interned at St. Joseph Hospital, Tacoma, Washington, and took a surgical residency from 1932 to 1935 at the Bridge Industrial Clinic also in Tacoma.

Dr. Shumsky established a practice in general surgery in Denver in 1936 which he temporarily left during 1942 to 1946 when he served in the military during World War II.

Dr. Shumsky was a member of the Colorado Medical Society, as well as of the Denver Medical Society and the American Medical Association.

He had served on the staffs of the Rose Medical Center, Mercy Hospital, Children's Hospital, St. Anthony Hospital, and Beth Israel Hospital.

His widow, Estelle Cohen Shumsky, survives as do two daughters, Mrs. Donald Hayutin, Denver, and Susan R. Shumsky, Rye, New York.

Doctor **Joseph B. McCloskey** of Denver died on June 27, 1980 at the age of 70.

Doctor McCloskey was born in Denver August 29, 1909, and attended Denver area schools, graduating in 1927 from St. Joseph High School. Prior to attending the University of Colorado Medical School he spent some time with the Civilian Conservation Corps and attended the University of Colorado where he received a BA degree. His MD was granted in 1941. He interned at Cleveland City Hospital, Ohio.

During World War II he served with the U.S. Public Health Service, from 1942 to 1946.

A general practitioner, Doctor McCloskey maintained a private practice, and served on the hospital staffs at St. Anthony, St. Joseph, Mercy, and Children's hospitals. In 1971 he suffered a heart attack, after which he retired.

He was a member of the Denver and Colorado medical societies, as well as the American Academy of Family Practice, and also Phi Rho Sigma medical fraternity.

He is survived by Mrs. Ruth McCloskey, three sons, John McCloskey, Pine, Colorado, Thomas McCloskey, MD, Aurora, and Richard McCloskey, Boulder, and four daughters, Mary Fran Soulis, Genesee, New York; Susan Reddick, Richland, Washington; Clare Lovett and Lois McCloskey, Denver. A brother, James E. McCloskey, and two sisters, Mary T. Rychiewski, Chicago, and Kathleen Williams, Arvada, also survive.

Doctor **William Mathews Bane** of Denver died July 2, 1980 at the age of 93.

Doctor Bane was born in Canonsburg, Pennsylvania on September 24, 1886, the son of Dr. William C. Bane, who practiced in Denver from 1891 until 1937, a total of fifty-seven years.

The family moved from Pennsylvania to Colorado in 1893, and Doctor Bane attended Emerson Grade School, then East High School. He attended Princeton University where he was graduated in 1908, then attended the Northwestern University Medical School, where he received his MD in 1912. He interned at Denver General Hospital.

In 1917 he enlisted in the Army Medical Corps and became an instructor in gas defense, and served at a hospital in a London suburb. After the war, Doctor Bane practiced with his father, and in 1924 the practice became limited to Ophthalmology. After his father's death, he was joined in his practice by Dr. Harry Shankel, and this partnership continued until thirty-two years later when he retired January 1, 1970, at the age of 83.

Doctor Bane was a member of the Denver and Colorado medical societies, as well as the Denver Clinical and Pathological Society, the Colorado Ophthalmological Society, the American Medical Association, the American College of Surgeons, the American Ophthalmological Society, the American Academy of Ophthalmology and Otolaryngology, and the American Association of Ophthalmology.

Doctor Bane is survived by his four daughters, Mrs. Isabel Boyle, Denver, Mrs. Barbara Chappell, La Jolla, California; Janet Bane, New York City, and Mrs. Marilyn Woods, Denver.



# DIRECTORY OF PHYSICIANS

It's been a long time in the making, but the Physician's Directory has been "put to bed." That means: it's in print and almost ready for distribution. The Physician's Directory for 1980 is different, in many respects, from any Directory in the past:

1. New listings for allied health agencies, including the important contacts and telephone numbers.
2. New information for a variety of emergency and non-emergency health and medical services, with telephone numbers.
3. All-new continuing medical education guide, with services provided by Colorado Medical Society Scientific Education Division and Council. Relicensure procedures and requirements for Colorado physicians.
4. Public health agencies and contact phone numbers.
5. State-wide hospital listings.
6. Guide to services provided by the Colorado Medical Society, and contact persons for these services.
7. Listing of physicians by SPECIALTIES, LOCATION OF PRACTICE AND REMOTE OFFICES AND CLINICS, all listings by TOWN or CITY, by COMPONENT SOCIETY MEMBERSHIP, areas of LIMITED PRACTICE.
8. COMPONENT SOCIETY officers and execs, with telephone numbers for that needed information contact.
9. Colorado SPECIALTY SOCIETY listing, with personnel and telephone numbers.
10. Listings of key persons in CMS and component auxiliaries, hospital and other health-related auxiliaries, medical assistants and related organization contact numbers.
11. Listing of health-related organizations.
12. CMS Code of Cooperation, with complete information concerning grievance procedures, media contacts, guide to handling medically-related information for public consumption.

These are just a few of the listings in this all-new book, which will be a serviceable, interesting adjunct to your office and practice. If you are not a member of Colorado Medical Society but have been accepted in the past as eligible to purchase one of the Physician's Directory, orders are now being taken. Call CMS, in Denver at (303) 861-1221, extension 261, to place your order. There are only a limited number of Directories that will be available (in August), so don't wait too long to place your order. This is a COLORADO-ONLY DIRECTORY, and does not include surrounding states.

# Gastro aortic fistula

## *Complication Following Thal Patch and Nissen Fundoplication*

James T. Harwood, MD, John B. Moore, MD, and Ernest E. Moore, MD, Denver, Colorado

***Chronic obstructive pulmonary disease comprises a category of pulmonary disease characterized by expiratory airway obstruction. Best managed when the pathophysiology of the disease is understood and a comprehensive approach utilizing nurses and respiratory therapy personnel is employed, it is ideally treated by several of the newer anhydrous theophylline preparations including selective Beta<sub>2</sub> agonists, and inhaled steroids which reduce morbidity and mortality and improve the quality of life of patients with COPD.***

### **Introduction**

The approach to the advanced benign esophageal stricture secondary to reflux esophagitis is technically challenging, and therefore is associated with significant complications. A gastro-aortic fistula developed two years postoperatively in a patient who had undergone an esophagoplasty with combined Thal fundic patch and Nissen fundoplication. To our knowledge, this is a previously unreported complication. A detailed case history and discussion of pathogenesis are presented.

### **CASE REPORT**

FK., a 70-year-old lady presented to Denver General Hospital (DGH) Emergency Room after an episode of syncope and hypotension secondary to a massive upper gastrointestinal hemorrhage.

This chronic alcohol abuser had multiple prior admissions to DGH for medical problems. The pertinent history began in 1970 when she presented to another Denver hospital complaining of recent dysphagia and weight loss. Workup showed an esophageal stricture secondary to reflux esophagitis. She had intermittent dilatations but was lost to followup.

The patient presented at DGH in July, 1974 complaining of intermittent sharp left chest pain associated with continued dysphagia and weight loss. Upper gastrointestinal series disclosed a stricture at the gastroesophageal junction with a sliding hiatal hernia and esophageal reflux. Endoscopy demonstrated a stricture at the 35 cm level not allowing passage of the endoscope. Multiple biopsies were taken and reported as benign. She underwent serial dilatations up to a 40 Hurst dilator and was discharged for outpatient dilatations and antireflux medical therapy.

In July, 1975, she was readmitted to DGH because of inability to tolerate solid foods. Upper gastrointestinal series revealed a fixed narrowing at the gastroesophageal junction 2 cm in length. Because of failure to respond to dilatation and antireflux medical therapy, the patient underwent a modified Thal esophagoplasty and Nissen fundoplication through a left posterior lateral thoracotomy. The strictured area was opened longitudinally on the lateral surface including 2 cm proximally on

the esophagus and another 2 cm distally onto the gastric fundus. A number 50 Hurst dilator was then passed from above by the anesthesiologist through the opened area into the stomach. The longitudinal esophagotomy was closed transversely in a two layered manner, and the fundus of the stomach was brought up and anchored over the esophagoplasty closure (not a true Thal patch). The remainder of the fundus was used to perform a Nissen fundoplication. Multiple 4-0 silk sutures were placed between the esophageal hiatus and the serosa of the stomach to prevent further herniation of the stomach. The hiatus admitted four fingers and was felt adequate to prevent obstruction of the fundus. UGI series one week postoperatively was consistent with the above surgery demonstrating an 8 cm fundoplication.

In November, 1975 the patient arrived at DGH with an acute upper-gastrointestinal bleed after an aspirin overdose and heavy alcohol ingestion requiring a two unit transfusion. UGI showed no ulcer with a stable fundoplication. Bleeding was attributed to gastritis and resolved.

She did well until May, 1977 when she presented with recurrent pneumonia. She also complained of intermittent sharp epigastric pain awakening her at night and occasional melenotic stools. The admission hematocrit was 28 per cent, but stools were hemitest negative. UGI demonstrated no change. Lower gastrointestinal evaluation was significant only for left colon diverticulosis. The anemia was therefore attributed to chronic disease and alcoholism, and after a three unit transfusion she was discharged with a hematocrit of 44 per cent.

She returned to surgery clinic six weeks later complaining of left upper quadrant pain over a two day period. Physical examination was unremarkable except for mild epigastric tenderness. The stool was mildly hematest positive. Hematocrit was 36 per cent, clotting studies and amylase were normal, and the abdominal X-ray series were unremarkable. She was started on a vigorous antacid regimen for possible peptic ulcer symptoms.

One week later she was brought to DGH Emergency Room after a syncopal episode with hypotension and diaphoresis. Systolic pressure was 60 mm Hg. Nasogastric aspirate was grossly bloody and hematocrit was 30 per cent. Vigorous resuscitation was undertaken with multiple large bore intravenous lines using crystalloid fluid initially and then type specific blood. Attempts at iced saline lavage were futile with continuous outpouring of gross bright red blood. Chest X-ray showed dilation of the hiatal hernia and the possibility of strangulation was entertained. Because of the massive exanguinating hemorrhage, the diagnosis of aortoenteric fistula from an aortic aneurysm was also entertained, but a cross table lateral X-ray failed to demonstrate evidence of an aortic aneurysm. The patient received 7 units of blood over a 45 minute period without stabilization of hypotension. Left thoracotomy with cross clamping of the thoracic aorta was considered, but thought contraindicated in light of her previous surgery. Aortography was also a consideration, but with unresponsive hypotension, urgent exploration was felt to be indicated.

Celiotomy disclosed gross free intraperitoneal blood and a massively dilated stomach. No strangulation of the stomach was noted and an anterior gastrotomy was performed. Two and



one-half liters of blood clot were quickly removed from the lumen of the stomach and a 5 × 5 cm perforation on the posterior wall of the stomach was noted. At this time the blood pressure fell and cardiac arrest ensued, which was unresponsive to resuscitation.

Postmortem examination revealed a gastroaortic fistula through the base of a benign gastric ulcer in the supradiaphragmatic stomach, 4 cm from the gastroesophageal suture line. The ulcer was 4 cm lateral and posterior to the gastroesophageal junction and was in an area of stomach that was firmly adherent to pleura and posterior mediastinal structures. The ulcer was 3.5 × 5 cm in size, and the stomach wall was notably attenuated in this area. An 8 × 10 mm area in the center of the ulcer had eroded through the wall of the descending thoracic aorta (Fig. 1). No malignancy was associated with this ulcer.



*Fig. 1. Postmortem specimen with arrow denoting fistula between stomach and aorta.*

### **Comment**

The surgical approach to advanced benign strictures of the distal esophagus secondary to esophageal reflux ranges from dilatation and anti-reflux procedure to plastic repairs of the distal esophagus to actual resection and intestinal interposition. Most benign reflux strictures can be definitively managed with intra-operative dilatation and anti-reflux repair.<sup>1,3</sup> The Nissen fundoplication, Hill posterior gastropexy and Belsey IV fundoplasty remain the established antireflux procedures.<sup>4,5</sup> In the unusual patient with transmural fibrosis and/or marked esophageal shortening, the more complex procedures may be necessary. A variety of ingenious esophagoplasties and resection procedures have been advocated.<sup>6,10</sup>

The combined Thal fundic patch and Nissen fundoplication was selected in this patient because of the presence of a tight stricture localized to the distal esophagus with transmural fibrosis.<sup>10</sup> Because of significant esophageal shortening, a considerable portion of gastric fundus was mobilized into the chest to perform the fundoplication, and approximately one-third of the stomach was left

within the thorax. The gastric serosa was sutured to the esophageal hiatus to prevent further migration. Vagotomy and pyloroplasty were not added to this procedure because of the lack of evidence for associated peptic ulcer disease.<sup>11</sup>

This patient developed a gastric ulcer within the intrathoracic portion of the fundus of the stomach. The etiology of this ulcer is of interest. There was no prior history of ulcer disease, and examination of the intraabdominal portion of stomach disclosed no ulceration or gastritis. The esophageal hiatus was approximately 8 cm in diameter. Despite this, review of postoperative chest roentgenograms showed air-fluid levels within the intrathoracic segment of stomach at various times, suggesting some degree of stasis either due to anatomic or functional obstruction. This particular anatomic situation is not unlike a paraesophageal hiatal hernia in which Hill has reported a 30 per cent incidence of ulceration with incarceration.<sup>17,18</sup> Other complications of incarcerated paraesophageal hernia, such as free perforation or hemorrhage from gastritis,<sup>19</sup> could also conceivably occur in this situation.

Controversy exists regarding the need for returning the stomach and the gastroesophageal junction to the abdomen following fundoplication. However, most recent evidence suggests that restoration of lower esophageal sphincter competence is a function of the fundoplication rather than returning the distal esophagus to the abdomen.<sup>4,19</sup> Thus, most surgeons do not feel compelled to place their fundoplications below the diaphragm in difficult cases. In this case, however, an excessive segment of stomach was mobilized. In retrospect, perhaps we should have considered the Collis gastroplasty combined with Belsey fundoplasty and intraoperative esophageal dilatation.<sup>8</sup>

The subject of intestinovascular fistulae has been extensively reviewed by Webster and Carey.<sup>12</sup> The most common etiology today is aortic reconstruction, usually with prosthetic graft material. Aortoesophageal fistulae have occurred with carcinoma of the esophagus and lung, tuberculous adenitis, thoracic aneurysms, and following coarctation repair. Spontaneous communication between the abdominal aorta and gastrointestinal tract has been described from the esophagus to the sigmoid colon. The most common cause is erosion of an arteriosclerotic abdominal aortic aneurysm into the duodenum. Other causes of abdominal aorta-enteric fistulae include mycotic, syphilitic, tuberculous and traumatic aortic and visceral arterial aneurysms, carcinoma of the pancreas, cervix and colon, perforated duodenal diverticulitis and duodenal ulcer, penetrating trauma, foreign body perforation, A-V malformations, tuberculous adenitis. Rarely, no demonstrable cause is discovered. Aortogastric fistula has been described as a

complication of aortic reconstruction,<sup>13</sup> with survival by direct suture repair.<sup>14</sup>

Most aorta-enteric fistulae present as upper and/or lower gastrointestinal bleeding, but the magnitude is quite variable. Often the hemorrhage is intermittent, and usually the first episode is non-lethal. This has been explained by temporary sealing of the fistulae by thrombus and/or contraction of the intestinal wall. Our patient presented with abrupt massive hematemesis which may be more typical of an aorto-gastric fistula.<sup>14</sup> Our patient also complained of moderately severe epigastric pain, which is unusual for aortoenteric fistula. The pain was probably due to massive gastric dilation and resultant perforation.

Spontaneous gastrocolic fistula has been described as a complication of benign gastric ulcer,<sup>15</sup> but we are unable to identify a report describing spontaneous communication with the aorta.

Esophagogastric fistulae have been described following combined procedures for benign esophageal stricture. In these cases the pathogenesis was felt to be related to bringing the altered esophagus in suture apposition to the stomach.<sup>16</sup> In our patient, however, the suture line was at least 4 cm from the gastric ulcer bed and site of aortic perforation. ●

Address for correspondence and reprints: Ernest E. Moore, MD, Department of Surgery, Denver General Hospital, W. 8th Ave. and Cherokee St., Denver, Colorado 80204, (303) 893-7045.

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## council on legislation

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The major item of business on the agenda for the June 19th meeting of the Council on Legislation was mental health. Carol Tempest stated that the fact that mental health is being studied in two interim committees (Judiciary and HEWI) indicates the importance that the legislature has placed on the issue. A position paper prepared by the Denver Medical Society's Committee on Mental Health was presented by Dr. Jack Klap-

per. The Council on Legislation recommended to the Board of Trustees that the Colorado Medical Society adopt the position and recommendations of the Denver Medical Society.

The Council is in the process of revamping the KeyMan program and all former KeyMen may expect to receive information on the new Key Contact program in the near future.



## MEDICAL OPPORTUNITIES

**COLORADO SPRINGS-EMERGENCY MEDICINE OPPORTUNITY AVAILABLE:** Emergency Medicine residency or two full years full-time experience required. Excellent compensation plus bonus. Malpractice provided. Contact: William Salmo, Chase Stone Center, Holly Sugar Building, Suite 440, Colorado Springs, Colorado 80903. Phone: (303) 471-4981.

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**AMERICAN PARA PROFESSIONAL SYSTEMS** seeks physicians to do basic examinations on mobile basis. Flexible hours, full or part time. Looking for physicians in Denver area and rest of state. Call: Martin Seldin, Director, (303) 758-3124, or write APPS, 2020 South Oneida Street, Suite #11, Denver, Colorado 80224.

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**WANTED-FAMILY PRACTITIONER** to take over 1/2 of busy, two-physician Family Practice in Denver, Colorado suburb. Salary with incentives first year - opportunity to buy into corporation at one year. Please send resume to Englewood Family Practice Clinic, PC, 3555 South Sherman St., Englewood, Colorado 80110.

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780-3-3B





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### OUR COVER

This month's cover is an original watercolor by Dr. Karon Aronson. Dr. Aronson is a member of the Colorado Medical Society. In addition to practicing medicine, she does medical illustrations and watercolor painting. Stationery cards with the cover painting and prints of the painting are available for purchase; call 321-0142 for information.

*Colorado Medicine* gratefully acknowledges Dr. Aronson's donation of the color separations for our September cover. Copyright of the painting remains with Dr. Aronson.

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Address all correspondence relating to subscriptions, advertising or address changes, manuscripts, organizations and other news items relating to editorial content to Editorial and Business Office.

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1601 E. 19th Ave.  
Denver, Colorado 80218  
Telephone (303) 861-1221

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*Colorado Medicine* (ISSN-0199-7343) is published monthly for \$12 per year by the Colorado Medical Society, 1601 East 19th Avenue, Denver, Colorado, 80218. Second-class postage paid at Denver, Colorado. POSTMASTER: Send address changes to *Colorado Medicine*, 1601 East 19th Avenue, Denver, Colorado 80218.

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# The abc's of lasers\*

Arlen D. Meyers, MD, FACS, Denver, Colorado

## Introduction

Recent advances in laser technology have heralded a new generation of biologic applications. With the advent of devices which can control laser energy through an operating microscope and an articulated arm, several authors began reporting uses of lasers in the management of various diseases.<sup>1</sup> Indeed, in a few short years since the advent of the laser, the device has quickly become a method of choice in the management of various laryngeal and aerodigestive problems.<sup>2,4</sup>

To understand lasers and their effect on tissue, a fundamental knowledge of physics is essential. This review is presented to familiarize the reader with those basic physical principles employed in laser technology in an effort to clarify the present modes of laser therapy and stimulate further research into other adaptations.

## The Nature of Matter

All matter is made of atoms, particles that move in random motion. As atoms get closer to each other, they repel each other and as they get farther apart, they attract each other. Atoms are composed of a nucleus composed of positively charged protons and neutral neutrons, and circulating electrons, which are negatively charged. The chemical properties of a substance depend on the number of circulating electrons.

When negative particles are placed close to positive particles, the particles feel a force. The ability to produce a force is called an electric field. The electromagnetic waves oscillate at varying frequencies. The rate at which a charge will move back and forth will determine the number of oscillations or cycles per second. Visible light occurs when the range of frequency is  $5 \times 10^{14}$  to  $5 \times 10^{15}$  cycles per second. Frequencies below this range are infrared and those above it ultraviolet. Higher frequency waves are X-rays and gamma rays are still higher.

Although early physicists portrayed oscillating particles in terms of waves, Einstein developed the Quantum theory and noted that at extreme high frequencies waves behave more like particles than waves.

The present concept of the subatomic structure of atoms is a tiny solar system. Electrons rotate around a small dense accumulation of protons

and neutrons. The number of positively charged protons in a nucleus is equal to the atomic number of the atom which is equal to the number of negatively charged electrons outside the nucleus. The atomic weight of an atom is equal to the total number of protons and neutrons in the nucleus.

Electrons reside in rings or shells around the nucleus. Only two electrons can occupy the shell closest to the nucleus. Eight can occupy the second shell, eighteen can occupy the third shell, and thirty-two the fourth shell. In each succeeding ring or shell, the electrons are found to be at a higher energy level with respect to the atom as whole. The energy level shells are labelled K.L.M.N. and so forth.

Within a given shell, the electrons exhibit different energy levels and are located in one or more subshells. The K shell has one energy level, the L shell has two sub levels, the M shell has three sub levels and the N shell has four sub levels. The lowest subshell of a given energy level is designated S, the next highest P, followed by D and F.

## Interaction of Light with Matter

Light is usually defined as electromagnetic radiation having a wave length between 300 microns and .01 microns. Electromagnetic radiation can interact with matter in three ways: 1. absorption, 2. spontaneous emission, and 3. stimulated emission.

Radiation is absorbed or omitted in bundles of energy referred to as quanta. An important characteristic of quanta of electromagnetic radiation is that absorption or emission can occur only if their energy is equal to the difference in energy between two allowed energy levels in the atoms, ions, or molecules making up the material with which they interact. As electrons go from a high energy state to a low energy state, quanta of energy are released. As quanta are absorbed, a low energy electron is elevated to a higher energy state (that is, occupies an electron shelf further from the nucleus). If the difference in the energy levels is E, then the frequency (V) of the radiation is equal to  $E/H$ , where H equals  $6.62 \times 10^{-34} \text{ WS}^2$  (Planck's constant). If the emission of radiation occurs in the absence of any quanta it is called spontaneous emission. If emission is induced by the presence of



quanta, it is called stimulated emission. Where spontaneous emission goes in all directions, stimulated emission tends to be emitted in the same direction as the stimulating quanta.

Given a population of high energy level and low energy level electrons, the probability of absorption occurring and stimulated emission occurring is almost equal. Whether one or the other occurs, therefore, depends on the number or population of high energy state electrons compared to low energy state electrons. If stimulated emission is to predominate, a large number of high energy electrons is required. In short, there needs to be a "population inversion".

## How is Laser Light Produced

The laser is a device which converts energy (light, heat, electricity) into radiate energy of one or more wave lengths. The word laser is an acronym derived from the first letters of the words Light Amplification by Stimulated Emission of Radiation. As previously described, the phenomenon of stimulated emission occurs in a carbon dioxide laser when electrically stimulated electrons of the CO<sub>2</sub> molecules attain a high energy state. The pumping means is an electric current flowing through a mixture of carbon dioxide, nitrogen, and helium gases contained in a glass tube. Mirrors at either end of the tube reflect the omitted waves which, after interacting with other high energy molecules, cause further stimulated emission of waves of the same wave length as the photon which struck it. Eventually, all the waves are reflected back and forth between the mirrors and, via a shutter-like apparatus, energy is released. The wave of energy which leaves the laser tube has unique characteristics. It is monochromatic (all the waves are of the same wave length), coherent (all in phase with one another), and collimated (all parallel to each other).

## How Laser Light Interacts with Biologic Tissue

As laser energy strikes biologic tissue, light energy becomes heat energy. The heat elevates the ambient temperature of the tissue to 100 degrees centi-

grade and flash vaporization takes place. When viewed with high speed cameras, the epithelium takes on the appearance of a blister, which bursts as expanding vapors reach the tolerance point of the tissues. As the blister breaks, the edges retract and an inverted bell-shaped crater is formed.

The crater formed is approximately 2 mm. in diameter when a 400 mm. lens is utilized. The depth of the crater varies, depending on the power of the laser, the time of laser exposure and characteristics of the tissue being radiated. Since the ability of tissues to absorb laser energy is high (absorption coefficient) there is little spread of heat around the crater and little adjoining tissue destruction. As a matter of fact, there is no noticeable destruction to be seen 500 to 600 microns from the edge of the crater when it is viewed microscopically.

TABLE I

LASER	SPECTRUM	DELIVERY SYSTEM	MOST FREQUENT USE
CO <sub>2</sub>	Invisible	1. Articulated arm 2. Microscope 3. Culoscope	Epithelial Dysplasias
Argon (skin)	Blue-green	Fiberoptic Handpiece	Superficial Vascular Lesions
Argon (eye)	Blue-green	Slit-lamp	Diabetic Retinopathy

## Summary

As laser technology is perfected, it is clear an expanded role in the treatment of many disorders will be found. Even today, fiberoptic delivery systems are being perfected, and more powerful and precise laser generators are forthcoming. In the near future, every specialist will find himself taking advantage of the qualities of this unique device. ●

\*From the Department of Otolaryngology, University of Colorado Health Sciences Center, and the Institute for Laser Medicine, St. Joseph's Hospital, Denver, Co. Address reprint requests to: Arlen D. Meyers, MD, FACS, 2005 Franklin St., Suite 650, Denver, Co 80205.

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## Rep. Wirth Shares Some Thoughts

Representative Tim Wirth met with a small group of Denver Medical Society physicians and with staff representatives of DMS, the Colorado Medical Society and the Colorado Foundation for Medical Care at the Medical Society Building the morning of July 14.

He was anxious to talk about the budget process, the overall expenditures by the federal government, and medical care which has climbed in three years from 8% of the total federal expenditure to 10%. Of the \$61 billion expenditure for the next fiscal year, \$54 billion are for Medicare and Medicaid only.

"If we are not able to figure out how we are going to control Titles XVII and XIX, there is going to be very little way that we can expect to be doing anything else in the area of medical care . . . the frustration is immense," he said. The Society Security program, medical programs, and veterans' programs will be big factors in driving up the federal budget from 20%-22% of the Gross National Product to 25%-28% of the GNP, Rep. Wirth feels. Coupled with the increased demands for more defense spending and a tax cut

on the other side, he says one gets the feeling "you can't get there from here." He feels his position on the budget committee is one of the hottest seats in Congress at the moment and described the "budget process as an effort to try to get some kind of rationality into an increasingly insane situation."

He feels government is going to have to say: "No, you can't have any more money" to many areas and also say: "We are going to have to cut out some programs" in other areas. "We are not going to be talking about any major new health insurance programs; we are not going to be talking about any new major initiatives in anything . . . until we are able to change a lot of these programs that are now lodged in legislation."

Discussion ranged from the validity of the government pushing HMOs to the costs of running for public office today, the future of PSROs, the possibility of a statutory limit on the U.S. budget, proposed changes in the components of the Consumer Price Index on which so many of our economical calculations are based, including the Cost of Living Index.

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# at press time ...

## NOTICE TO MED EXECS:

COLORADO MEDICINE was notified in August of the resignation of Ed Collins as Executive Director of the American Association of Medical Society Executives, effective September 1, 1980. John Reinman, President of the AAMSE, has asked that we publicize the position opening, stating that:

"Ed's contributions for these three and one-half years have been most effective and we are indeed sorry to see him leave. However, we must continue to move forward and we desire to fill the position with the most capable person available.

I have been asked by the Board of Directors of AAMSE to serve as Chairman of the Search Committee. We have received a number of applications for the position but are most anxious to generate as many candidates as possible before the Search Committee makes a final decision."

Interested parties should respond directly to:

John Reinman, President, AAMSE  
Pennsylvania Medical Society  
20 Erford Road,  
Lemoyne, Pennsylvania 17043

All applications will, of course, be held in the strictest confidence.

## COLLEGE TO EXPAND MEMBERSHIP DEVELOPMENT

Fellows of the American College of International Physicians, Inc., have recommended to the college's Board of Trustees an expanded membership development program to recruit more interested physicians into the college.

The College provides a forum for discussion of issues of vital interest to international physicians and international medicine. It is actively working to help create a climate conducive to the development of the full potential of all international physicians now practicing in the American continent and is helping to formulate the national interest in international health activities because of the unique internationality of its Fellowship and its expertise in the health needs of countries abroad.

Fellowship information and application forms can be obtained by writing the College's office at 3030 Lake Avenue, Fort Wayne, Indiana, 46805, or by calling (219) 424-7414.

## INFLATION AND CMS - THE EFFECT ON YOUR DUES DOLLARS

What is the national and local inflation doing to your dues dollars? With the publication in August of the Consumer Price Index the dollar is severely taxed to keep up the works of the Colorado Medical Society. Using 1967 as a "base year" (100.00), inflation has risen to the level of an estimated 267.5 in the Denver area.

Looking at the dues dollars in CMS over a three year period, here's what has happened:

CMS FISCAL YEAR	8/1/77	186.5
	8/1/80	267.5

During those three fiscal years, then, inflation is up 81 points, or 43.3% in three years.

Nationally, a view of the Consumer Price Index (C.P.I.) for 1967 through 1975 shows the following:

Base year	1967	100.0
	1973	138.5
	1975	166.3
	1977	191.5 **
	1978	214.2 **
	1979	246.6 **
Estimated -----	1980 (August)	267.5 **

An example of what effect inflation will have on CMS expenses over the next five years using an 8% inflationary factor and NO program changes:

\$1,400,000	Present year
1,512,000	1st year
1,632,960	2nd year
1,763,597	3rd year
1,904,685	4th year
2,057,059	5th year

47% MORE DOLLARS NEEDED TO MERELY MAINTAIN EXISTING PROGRAMS!

If inflation were at 12% per year, it would take 76% more dollars to maintain existing programs.



# **American Medical Association**

## **PRINCIPLES OF MEDICAL ETHICS**

**as adopted by the AMA House of Delegates**

**July 22, 1980**

Preamble: The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility not only to patients, but also to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

- I. A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.
- II. A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception.
- III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.
- IV. A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law.
- V. A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.
- VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services.
- VII. A physician shall recognize a responsibility to participate in activities contributing to an improved community.

# MINUTES OF THE MEETING OF THE COUNCIL ON INTERPROFESSIONAL RELATIONS

August 14, 1980, 5:00 p.m.

## Digest of Minutes and Actions.

1. The Council endorsed the Rocky Mountain Drug Consultation Center as a conscientious attempt to keep physicians up-to-date on proper drug usage. The Council will ask the editors of COLORADO MEDICINE to accomodate articles by the Center as space allows. The Council has asked the Center for the right to let Pharmacy Committee members audit its medical advisory board meetings.
2. It was agreed that the Medical Society must oppose continued attempts by the pharmacy profession to regulate physician prescribing and dispensing habits. A letter will be written to the Colorado State Board of Pharmacy opposing any attempts to limit physicians' historical and legislative rights. The Pharmacy Committee is to appoint some of its members to become knowledgeable about the physician-pharmacy interface. Those members might then become speakers for Society-sponsored legislation clarifying physician rights vis-a-vis pharmacy board regulation.
3. Members discussed a draft dated May 14, 1980, which proposed a new kind of worker, the Health Care Technician, for provision of patient care at Denver General Hospital. The Council is opposed to technicians as portrayed in the May 14 draft for the same reason that it supported amendments to the most recent Nurse Practice Act. We are opposed to people practicing medical acts who are not qualified for their role by virtue of their formal training.
4. The Council saw no reason to activate the Joint practice Committee at this time.
5. The Council approved the submission of a resolution supporting imprint identification of legend drugs for the discussion of the House of Delegates of CMS at the 1980 Annual Session in September.

Wallace H. Livingston, M.D.

## COLORADO MEDICAL SOCIETY GETS NEW EXECUTIVE DIRECTOR

Effective the first week of September, the Exeutive Director of Program Administration, Colorado Medical Society, is CHUCK MARCUS, who has been the Director of the Data Systems and Technical Support Division of the Colorado Foundation for Medical Care since December of 1979.

Chuck has been with CFMC since May of 1977 when he came from Blue Cross/Blue Shield with 5 years experience in a variety of their programs, giving him a broad base in health care and insurance industry.

Chuck Marcus graduated from Wentworth Military Academy with a degree in Political Science and Economics. He served two years as a Commissioned Officer in the U.S. Army Military Intelligence, assigned to South America, the Panama Canal Zone and Southeast Asia (Viet Nam) as a decorated member of the Green Beret.

Chuck is a native Coloradan. He is married and has two children. One of his primary hobbies is work. As soon he is totally oriented to the Colorado Medical Society responsibilities, Chuck plans to continue his graduate-level study in economics at the University of Colorado. We welcome Chuck Marcus to Colorado Medical Society and view his inclusion to the staff as a valuable addition.



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Second Annual Vail General Dentistry  
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*Lion Square Lodge, Vail, Colorado*

**February 14-21, 1981**

Seventh Annual Vail OB/GYN Conference  
*The Mark Resort, Vail, Colorado*  
Sixth Annual Vail Psychiatry Conference  
*Lion Square Lodge, Vail, Colorado*  
Third Annual Vail Geriatric  
Medical Conference  
*The Lodge at Vail, Vail, Colorado*

**February 21-28, 1981**

Eleventh Annual Aspen Radiology Conference  
*Aspen Institute for Humanistic Studies*  
Second Annual Vail Pathology Conference  
*Kiandra-Talisman Lodge, Vail, Colorado*

**February 28-March 7, 1981**

Fourth Annual Vail Cancer  
Treatment Conference  
*Kiandra-Talisman Lodge, Vail, Colorado*  
Third Annual Vail Sports Medicine Conference  
*Lion Square Lodge, Vail, Colorado*

**March 7-14, 1981**

Sixth Annual Vail Family Practice Conference  
*The Mark Resort, Vail, Colorado*  
Sixth Annual Vail General Surgery Conference  
*Lion Square Lodge, Vail, Colorado*  
Fourth Annual Vail Urology Conference  
*Kiandra-Talisman Lodge, Vail, Colorado*

**March 14-21, 1981**

Sixth Annual Vail Internal Medicine  
Conference  
*Lion Square Lodge, Vail, Colorado*  
Third Annual Vail Pediatrics Conference  
*The Mark Resort, Vail, Colorado*  
Second Annual Vail Clinical  
Brain Conference  
*Kiandra-Talisman Lodge, Vail, Colorado*

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Membership Development at 312-751-6410, 535 N. Dearborn St., Chicago, IL 60610.



It occurs to me that this is the last opportunity I will have to address you from this perspective in COLORADO MEDICINE and, although I will still have an opportunity to stand before you or your delegates at the Annual Session of the House of Delegates later this month, I won't be able to say all I would like about my experience as your President before I leave office. In fact, I'll probably be thinking and talking about this year's experience for the rest of my life. It has been that meaningful.



Most important at this writing, however, is to recall a few of the things I have learned in this job: after the many years that I have been in practice I have re-learned just how complex life is beyond the office, the clinic or the hospital; after being associated with so many of you in the Medical Society and in the medical profession in general, I have come to know you on an entirely different plane, and it was as if I had never known you before. I learned, or was reminded again, of the complexities of corporate business and how dependant an executive officer must be on his staff and on his associates for advice and direction. I was also taught the joys of some minor (or major) victories in the marketplace, and fraught with the sorrows of the minor (or major) defeats. These things, these ups and downs, peaks and valleys, happened to me on a daily basis during the entire time I have held this office. Interestingly enough, there is a saving grace: though the daily pressures of the peaks and valleys tend to have a serious affect on a person's overall abilities, temperament, emotions, etc., the peaks were nicely offset by the valleys, and vice versa.

During this year we have made some major, productive strides:

- The Colorado Medical Society has entered the decade of the '80s in a progressive attitude and posture.

- The reorganization of the Society to conform to the needs of this decade have now been reshaped and redirected to make for a more efficient flow of business before the House of Delegates and the Board of Trustees.

- Goals of the Society have been studied and strengthened, objectives and activities have

been restructured.

- The Colorado Medical Society has, for the first time in recent history, taken a pro-active stance in matters of the good of the public health.

- CMS has accomplished a more positive public image through its efforts.

- The new slate of officers has a firm footing on which to begin their term of office and continue to build a better professional organization.

- The first Component Society Officers' Meeting was held and was a success.

- The CMS relationships and communications with the component groups have been steadily improving during this year.

- A campaign to return the motorcycle helmet law to the Colorado statute books did not put the proposal on the ballot, but it was successful in alerting the public to a crying need for the effort to thwart this growing, dismal statistic of injury and death. The public reaction was positive, throughout the campaign.

- The Colorado General Assembly is primed to carry the helmet law on the 1981 call, with the support of the Society.

- The CMS Auxiliary has had one of its most productive years ever, with contributions from every component of the Auxiliary in the state, and with excellent response from the public and private sectors.

- The Colorado 6th Rural Health Conference will be held in October, but it will be the forerunner to the National Rural Health Conference, which will be held in Denver in March, 1981. This is indicative of the interest and progress in Colorado's rural health. Colorado Medical Society has had a long and continuing participation in the rural health field.

There is no way to fully explain the rigors of the honor and the responsibility that go with the job of President of Colorado Medical Society. There is only one way to express my appreciation to each of the members of this Society for having helped me every step of the way through this totally new experience: My heartfelt thanks to each of you for your patience, your consideration, your support and your continued personal and professional friendship.

*Ray S. W. Peterson*

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# obituaries

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Doctor **Henry B. Streng** of Boulder died July 7, 1980 at the age of 66.

Doctor Streng was born in New York City April 21, 1914, attending public schools in that city before entering Rensselaer Polytechnic Institute for his pre-medical work.

He received his MD from Yale School of Medicine in 1939, and interned at New Haven, Connecticut Hospital, New Haven. He took additional training in pediatrics at John Hopkins University Hospital, Baltimore, and at Strong Memorial Hospital, Rochester, New York.

He served during World War II in the U.S. Army Medical Corps overseas with the 100th General Hospital. Following his return, he took a second year of pediatrics training at Rochester.

From 1947 until 1957 when he came to Colorado, Doctor Streng was professor of pediatrics at the University of Oklahoma Medical School.

In 1957 he joined the University of Colorado Health Sciences Center as clinical professor of pediatrics.

As a member of the Boulder County Medical Society he was chairman of its School Health Committee. Earlier he was president of the Colorado chapter of the American Academy of Pediatrics. He was a member of the Colorado Medical Society.

He is survived by his widow, Mrs. Kathryn Streng, and a daughter, Christina Mitchell, Longmont, and a son, Stephen N., Lafayette.

## **New Staff Assistant for Colorado Consortium for CME**

Virginia Adler has just assumed the position of half-time Program Assistant to the Colorado Consortium for Continuing Medical Education. She replaces Kathy Gardiner who left to take a full-time supervisory position. Virginia has had specialized education and training in the area of health administration and education, which includes being a licensed RN, having a BA Degree in Community Health Education, and an MS Degree in Health Administration from the University of Colorado.

Virginia will assume responsibility for several on-going projects of the Consortium, including "Hot Topics" which will provide general physicians with information about specialized clinical topics which should be of interest to them.

## **In Washington**

As anticipated, a bill has been introduced by Representative Richard Gephardt (D-Mo.) and Representative David Stockman (R-Mich.) which is intended to deregulate the health care industry. The new plan would replace \$60 billion in federal Medicare/Medicaid outlays and IRS tax expenditures with consumer choice vouchers and hopefully would improve the quality, equity, and efficiency of our current system. The legislation would provide for government health care subsidization to a stated limit, of an individual's health care cost; and that individual could choose the plan of his choice. These plans could be sponsored by physicians, hospitals, Blue Cross-Blue Shield, commercial insurance carriers, etc.; thus, the free market disciplines would replace government regulation.

Early reports indicate a guarded acceptance of the concept by national physician and hospital organizations.

## **CHA Executive Praises New CME Handbook**

In a recent letter, Larry Wall, Vice President of Rural Hospitals and Operations at the Colorado Hospital Association, wrote as follows about the new CME Handbook published by the Colorado Consortium for Continuing Medical Education:

"... I find the document to be an excellent resource for those physicians responsible for continuing medical education. It is also a fine resource for other individuals in the hospital setting who might be involved in education but have little or no training in educational processes. All of the chapters provide quite specific and pragmatic information regarding educational processes.

"Of special interest and detail are the chapters regarding choosing the right methods for teaching and learning, evaluating the continuing medical education teacher, evaluating the effect of an educational program on participants, and preparing and using visual aids in CME teaching.

"The handbook also contains an excellent bibliography on where one can gain access to additional educational materials. The handbook is easily readable and provides basic information in a very straightforward practical fashion.

"Having met the challenge of creating an excellent document which speaks to the how-to of the educational process, it seems as though the next step for the consortium is to develop a similar handbook on the how-to for medical care evaluation for the small rural hospital medical staff of 3-4 physicians. Keep up the good work."



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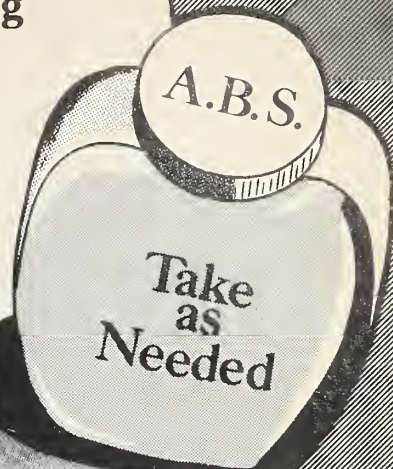
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# Peripheral vascular disease\*

## *A Comparison Between the Vascular Laboratory and the Arteriogram in Diagnosis and Management*

Charles O. Brantigan, MD, Denver, Colorado

Interest in noninvasive technic for evaluation of peripheral vascular disease arose in the 1950's with the advent of arterial reconstructive surgery. Early investigators studied the use of segmental limb pressures,<sup>1</sup> arm to ankle indices,<sup>2</sup> doppler flow meters,<sup>2</sup> plethysmography,<sup>3</sup> and exercise testing,<sup>4</sup> often comparing results with surgical findings rather than arteriography, which was embryonic at that time. Each technic had its advantages and disadvantages, but by 1960 Travis Winsor *et al.*<sup>5</sup> combined noninvasive technics to produce a system which would give valuable and accurate diagnostic information. Arteriography developed at the same time rapidly became the sine qua non of vascular surgery. Arteriography produced a very precise map for the surgeon planning a reconstruction. In the 1970's it became apparent that physiologic information as well as anatomic information was required to plan a vascular reconstructive procedure intelligently. Arteriography had a very limited role in patient screening and followup evaluations. Interest in physiologic noninvasive testing was thus again stimulated, and the concept of the vascular laboratory emerged.

Building on the work of others, Raines *et al.*<sup>6</sup> combined doppler segmental pressures with segmental plethysmography and exercise testing into a system virtually identical to that devised by Winsor a decade before. Standards for diagnosis were established. The PVR machine was packaged and marketed by Life Sciences Inc. as a vascular laboratory which could be purchased and used immediately. Testing could be carried out by a technician and compiled into a report read by a physician, usually a vascular surgeon. Physiologic data became a permanent part of the patient's record and, like the electrocardiogram, was available for subsequent comparison. Tests used are painless, noninvasive, virtually without risk, and are available on the request of any physician. The availability of equipment in an easily used form complete with established standards has led to the

establishment of vascular laboratories in most hospitals in Denver.

In attempting to define the use of this new modality of testing it must be compared to more established methods of diagnosis such as arteriography. Arteriography is considered the definitive diagnostic test for arterial occlusive disease by most physicians. It is entirely an anatomic test. Although comparing anatomy and physiology is a bit like comparing apples and oranges, the present study was undertaken to determine the correlation between noninvasive physiologic testing and invasive anatomic testing. By examining the concordance between the two modalities of testing and by studying their differences of opinion the role of the vascular laboratory in the management of peripheral vascular disease can be easily defined. In addition, the strength and weaknesses of the two modalities of testing can be determined as well as the areas in which the two modalities of testing are complementary. Such a comparison will define for physicians the role of noninvasive testing in the diagnosis and management of peripheral arterial disease.

### **Materials and Methods**

The Noninvasive Vascular Laboratory was established at Presbyterian Medical Center in Denver in 1977. Since that time 345 arterial evaluations of the lower extremity have been carried out, 210 with treadmill testing. 97 venous studies have been done. Cerebrovascular testing was added in 1978, and 223 of these evaluations have been carried out. The present study included the first 57 patients who had both arteriography and vascular lab evaluations of the lower extremities carried out in close enough proximity for comparison.

The vascular lab evaluations included segmental limb pressures and segmental plethysmography tracings carried out using the technics described by Raines *et al.*<sup>6</sup> Rutherford and Kempczinski<sup>7</sup>



and others.<sup>8</sup> Exercise testing was used when appropriate, and EKG monitoring was used only in patients considered at risk for the development of cardiac difficulties. Single plane arteriography was carried out using standard technics. For purposes of comparison, each leg was considered to be made up of three segments, the aortoiliac, extending to the femoral artery bifurcation, the superficial femoral segment, extending to the popliteal trifurcation, and the tibioperoneal segment, extending to the ankle. Information was occasionally generated concerning more distal vessels - feet and toes can be studied by both modalities. Since this data is useful in only specific circumstances, it will not be considered further. Arteriograms were read by the radiologists performing the study, and vascular lab studies were interpreted by the author. For each segment of each leg, the arteriogram report and vascular laboratory were compared. If an opinion concerning a degree of occlusion of any segment was reported in an ambiguous fashion, or the studies disagreed, they were reread by a radiologist and/or by the author as appropriate. Some segments on some patients could not be evaluated by both modalities for a variety of reasons. The most prominent of these reasons included amputations, necrotic lesions preventing application of lab instruments, limited studies or proximal disease so severe that distal flow could not be demonstrated by one or the other modality. As a result, the number of data points is different for each leg segment.

## Results

Review of arteriograms generally resulted in refinement of readings rather than a change in diagnosis. A reading such as "moderate diffuse arteriosclerosis" was reread as "moderate diffuse arteriosclerosis producing a 60% narrowing" or "moderate diffuse arteriosclerosis with no areas of significant stenosis." Such rereadings produced an upgrading of the significance of the lesion in many patients, particularly in the aortoiliac segment, and led to an improved concordance between the two modalities of testing. Review of vascular studies showed one error made by the author in reading a femoropopliteal segment, and one error in reading a posterior tibial segment.

Data concerning the aortoiliac segment could be compared in 109 arteries. The initial concordance between the studies was 88 per cent. Review of the arteriograms upgraded this concordance to 96 per cent. One extremity of the 109 had a lesion

involving the orifice of the superficial femoral and profunda femoris arteries. This was read by the vascular laboratory study as aortoiliac disease, and was considered a correct diagnosis as it fits the definition of the segments. There were three other patients who had disease involving the orifices of the profunda femoris artery and superficial femoral artery, but these patients also had aortoiliac disease, and were interpreted correctly. In this segment there were four discrepancies of interest. One patient who had a hemodynamically significant aortoiliac lesion by physiologic testing, but whose lesion was felt not to be arteriographically significant healed his gangrenous great toe after bypassing that lesion. One patient whose aortoiliac lesion was deemed significant by physiologic testing but not by arteriography was relieved of claudication and had an appropriate improvement in noninvasive testing following bypass of that segment. One patient whose aortoiliac lesion on the asymptomatic side was considered insignificant by physiologic testing but significant by arteriographic testing remained asymptomatic following bypass, showed no change in his postoperative vascular laboratory examination. In one patient, whose aortoiliac segment was considered hemodynamically normal by vascular laboratory but abnormal by arteriography, both studies agreed that the most significant lesion was the occluded superficial femoral artery on that side. No postoperative data is available for comparison in this patient. With the exception of the above reservations, no patient with a normal arteriogram was read as abnormal by the vascular laboratory, and no superficial femoral artery occlusion was misinterpreted as aortoiliac disease.

In the superficial femoral segment there were 101 arteries available for comparison. The initial concordance was 89 per cent which was upgraded to 91 per cent following reinterpretation of studies. In the tibioperoneal segment 81 arteries were available for comparison. The initial concordance was 90 per cent and after reinterpretation of the studies the concordance was 96 per cent. The tibioperoneal segment was considered normal if one of the three vessels was normal. Adding all of the arterial segments together, there were 291 arterial segments available for comparison. The initial concordance was 89 per cent, and after reinterpretation of the studies the concordance was 95 per cent.

The vascular laboratory evaluation was most accurate in identifying patients who were without hemodynamically significant arterial occlusive

disease and patients with disease confined to one arterial segment per extremity. The patients in this series however included a large number of patients with complex multisegment disease. Forty-four extremities in these 57 patients had combined aortoiliac and superficial femoral artery lesion. Of these forty-four extremities, physiological and anatomic testing agreed in 37 patients. Aortoiliac disease was missed by the vascular laboratory evaluation in two patients, and the superficial femoral disease was missed in five patients. The patients in whom aortoiliac disease was missed had a mild aortoiliac lesion compared to the superficial femoral lesion. Although the concordance between noninvasive testing and arteriography was not as great in this group of complex patients, the most significant lesion was identified correctly in all patients, and an isolated superficial femoral lesion was never interpreted as an aortoiliac lesion.

### Discussion

Many physicians believe that the diagnosis of peripheral arterial disease is simple, requiring only a good history and physical examination. Although the diagnosis may often be easy, particularly to an experienced vascular surgeon, accurate evaluation of peripheral vascular disease may be very difficult. Although the clinical evaluation, including history and physical examination, is important, not only has it real limitations, but it may be misleading as well. The medical literature is full of enthusiastic reports of now abandoned forms of therapy evaluated solely by patient testimony. The history of claudication, cramping or pain in the calf or buttocks aggravated by walking, and requiring that the patient stop, is a characteristic history. Claudication may evolve into ischemic rest pain, which is characteristically severe and not relieved even by narcotics. Unfortunately, compression of the cauda equina by bone spurs or discs can produce the typical history of claudication as well. In addition, neuropathy most commonly caused by diabetes can produce pain in the extremities, and even pain which appears to be ischemic rest pain.

Physical examination adds information to the history but also has very severe limitations, both in the way it is performed and in the information it provides. Measurement of blood pressure in the arm is part of a routine physical examination, but how often is ankle blood pressure measured? Arterial hypotension is, after all, one of the most reliable physical findings in peripheral vascular disease. The most commonly used objective physical

finding is the presence or absence of pulses. Although palpitation of pulses may provide valuable information, there is a high degree of observer variability in documenting the presence or absence of pulses. Lubdbrook *et al.* (1962)<sup>10</sup> in a study of 239 subjects found that there was no more than an even chance that when one observer found a missing dorsalis pedis pulse that the other two observers in the three man study would agree with him. Similar variability was observed in detecting the posterior tibial pulse. If observer variability were not a problem, congenital absence of a pulse could provide misleading information. The dorsalis pedis is congenitally absent in from 4 per cent to 12 per cent of subjects, and the posterior tibial congenitally absent in from 0.24 per cent to 12.8 per cent of subjects.<sup>10</sup> To complicate things further, a patient may have arteriosclerosis with loss of one of the pedal pulses, but not have arteriosclerosis as the cause for symptoms. Pulses may disappear in calcific medial sclerosis without significant compromise of flow. Trophic changes of the skin of the extremity are important clinical signs. In examining the patient with arterial occlusive disease, one looks for thin shiny skin with atrophy of the nails, and hair loss over the extremity. Cyanosis and ulcers are important physical findings as well. Unfortunately, cyanosis can be caused by vasospastic disease as well as arterio-occlusive disease. Ulcers are commonly caused either by arterial insufficiency, venous insufficiency or diabetic neuropathy. In more complicated situations a patient may have the presence of several coexisting diseases. While the presence of arteriosclerosis may be identified on physical examination, other coexisting diseases may be more important than the arteriosclerosis. Arteriosclerosis thus detected may be clinically insignificant.

The failure of clinical evaluation to identify the significance of arterial occlusive disease has been objectively documented. Barnes *et al.* (1976)<sup>11</sup> in assessment of 50 patients undergoing 53 below the knee amputations found no correlation between the incidence of healing and appearance of the skin short of gangrene, level of the most distal pulse, presence of diabetes, or even with bleeding noted during the time of surgery. Marinelli *et al.* (1979)<sup>12</sup> studied 458 diabetic patients using clinical evaluation and noninvasive testing. Eleven per cent of the patients in this study with a history of claudication were hemodynamically normal. Of the patients with no history of arterial occlusive disease 31 per cent had hemodynamically significant arterial occlusive disease. One fifth of the patients with a normal physical examination had



hemodynamically significant arterial occlusive disease. While history and physical give some information concerning the presence or absence of an arterial occlusive disease, clearly a more definitive evaluation is required.

Arteriography, either by the translumbar or transfemoral route, is the diagnostic test which makes vascular surgery possible. Arteriography, the standard against which all other diagnostic studies are measured, provides an accurate arterial roadmap, and thus, it is indispensable to the surgeon who must know the condition of the vessel at the point where he plans to operate. The test is expensive and invasive and carries a certain morbidity of its own. Arteriography cannot be reasonably used in the serial followup of patients with known arterial disease or previous vascular surgery and is not undertaken merely on the suspicion of arterial disease. In most institutions arteriography is carried out in a single plane and thus gives only a two dimensional view of a three dimensional vessel. In addition, although highly accurate in identifying lesions, it can give no information about their physiologic significance.

The limitations of aortography in accurately assessing the physiologic significance of lesions in the aortoiliac system is well known. Most experienced vascular surgeons, in fact, assume that the arteriogram, particularly in this segment, will usually underestimate the extent of lesions present. Haimovici (1967)<sup>13</sup> concluded "with the present angiographic techniques it is important, therefore, to bear in mind that the pathologic findings are much more pronounced than the arteriographic outline would suggest." The errors produced by a single plane arteriography are very well diagrammed in an article by Moore *et al.* in 1971.<sup>14</sup> If there is a large posterior plaque in the common iliac artery, the dye may spread out in a thin ribbon across the full diameter of the artery, giving the appearance of a normal artery in the AP view. A lateral x-ray would show the thin ribbon and obstructing lesion. In addition, changes in the viscoelastic properties of the vessel as well as irregular surfaces producing turbulence are not accurately portrayed in an arteriogram. Vascular surgeons have been concerned about this limitation of arteriography as the most common cause of failure of a distal reconstruction with presence of unrecognized proximal disease. Moore *et al.* (1971)<sup>14</sup> studied 40 patients with intermittent claudication whose aortograms failed to show iliac stenosis. Direct femoral artery pressure measurements before and after exercise showed that 28 of the 40 patients had hemodynamically significant

aortoiliac disease in addition to the documented superficial femoral artery disease. Seventeen of these 28 patients underwent simple correction of their aortoiliac disease with resolution of symptoms in 95 per cent of patients. They concluded that "making physiologic interpretations from angiographic data can lead to surgical errors." Had the diagnosis in these patients been limited to arteriography, 18 of the 28 patients would have been considered for an ill-advised femoropopliteal reconstruction.

Other means of physiologic testing have been combined with arteriography. Brenner *et al.* in 1974<sup>15</sup> recommended combination of arteriography with reactive hyperemia and direct femoral artery pressure measurement. A fall in femoral artery pressure of greater than 15 per cent after induction of reactive hyperemia, confidently predicted the presence of a proximal lesion. Their study of 90 limbs showed that in three-fourths of the instances in which the pressure study was normal the arteriogram showed "moderate" or "severe" disease. Despite this conflict, femoropopliteal grafting was successfully carried out in all 15 patients with objective improvement demonstrated physiologically. In addition, despite the fact that 94 per cent of the patients with an abnormal femoral artery pressure study were felt to have "moderate to severe" morphologic abnormalities by aortography, only half (9 of 17) were felt to have hemodynamically significant lesions. Proximal reconstructions were carried out with objective physiologic improvement documented in all patients. These authors found that aortography could be misleading even in two planes. Similar results were documented by Quin *et al.* (1975).<sup>16</sup> In the present study, two patients in whom hemodynamically significant aortoiliac lesion diagnosed physiologically were not confirmed arteriographically. Objective improvement following aortofemoral bypass was documented. Sethi *et al.* (1977)<sup>17</sup> summarized the limitations of single plane aortography, recommending that arteriographic studies be repeated in two or more planes if: 1. The symptoms fail to correlate with the arteriographic findings; 2. The patient has had a previous bifurcation graft; 3. The patient is being considered for femoropopliteal bypass grafting - elimination of proximal obstruction is critical in these patients; 4. The patient has a focal iliac lesion - to make sure that there are no others; 5. The patient needs an evaluation of the profunda femoris artery - orifice lesions are not accurately identified in an AP view. In summarizing the work of these authors we can conclude that pressure gradi-

ents across a 75 per cent diameter stenosis read by arteriography will generally be significant. Patients who have an entirely normal arteriogram will probably have no demonstrable pressure gradients. Patients in the middle group (20% to 75% stenosis) will not have the hemodynamic significance of their lesions predicted accurately by arteriography, and further physiologic testing will be required using direct pressure measurements or by vascular laboratory study. Physiologic testing thus compliments arteriography.

Many individual physiologic tests have been proposed in an attempt to diagnose peripheral vascular disease noninvasively and to quantitate its physiologic effects. Our preference has been to use the simple methods. The use of segmental pressures to determine the location of peripheral vascular lesions has been used since the classic article by Travis Winsor in 1950.<sup>1</sup> He documented what

TABLE 1

NORMAL VALUES FOR SEGMENTAL LIMB PRESSURES  
UNIVERSITY OF COLORADO DATA (28)

	Pressure	Ratio
Brachial	128 $\pm$ 27	1
Thigh	158 $\pm$ 31	1.24
Calf	148 $\pm$ 34	1.16
Ankle	138 $\pm$ 28	1.08

constituted a normal pressure measured at the thigh, above the knee, below the knee, at the ankle, metatarsal level and great toe level. Similar studies have been carried out by many authors since that time. (Table 1) In general, due to arterial elasticity and reflected waves, the thigh blood pressure should be somewhat higher than the brachial blood pressure. A gradient of 20 mm Hg between the blood pressure measured at each of these segments or between corresponding segments of the opposite extremity is considered significant in localizing a lesion. Some investigators have reduced this data to a ratio, but we have not found this helpful. Such testing, although reliable in identifying arterial occlusive disease, has limitations when used by itself.<sup>18</sup> Since the blood flow to a claudicating extremity is normal at rest, there may not be a pressure gradient across a critical level of stenosis which compromises flow only during exercise.<sup>19</sup> In addition, since the proximal

blood pressure cuff really encircles the proximal superficial femoral artery instead of the common femoral artery, simple doppler blood pressure determination is unable to distinguish between a proximal superficial femoral artery lesion and a lesion in the aortoiliac system.<sup>7</sup> In addition, severe medial sclerosis, commonly seen in diabetes, may make the artery incompressible and lead to falsely elevated blood pressure readings.<sup>18, 20</sup> If a foot looks ischemic, and the ankle pressure is greater than 300mm Hg, this problem is easily detected. If, on the other hand, the patient has an ischemic looking foot and an ankle pressure of 80mm Hg, blood pressure recorded may be falsely high and lead to wrong decisions. Clearly, more information is required than that provided by segmental pressure readings.

Segmental plethysmography is not deceived by medial sclerosis. Using the same positions as used for segmental blood pressure measurements, a plethysmographic tracing is recorded. A segmental plethysmographic tracing is virtually superimposable upon the tracing obtained by arterial puncture at that level.<sup>21</sup> Assessment of morphology allows prediction of stenosis. According to Winsor,<sup>22</sup> as a vessel becomes more stenotic, the reflected wave ("dicrotic notch") disappears. The upstroke of the tracing becomes slurred, and the amplitude decreases. The crest time (time from the onset of the systolic pressure wave to its peak) lengthens. (Fig. 1) Attempts have been made to quantitate these changes, and heavy reliance has been placed on amplitude of the signal. Our experience has shown a qualitative appraisal of

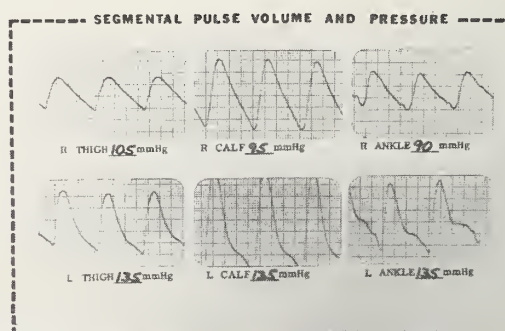
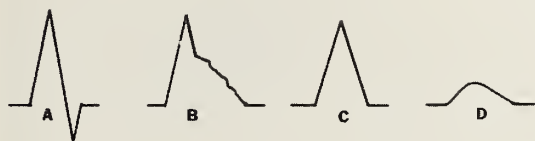


Fig. 1. Segmental Pulse Volume and Pressures

This is a typical record from a patient who has an isolated iliac lesion. The plethysmographic tracing of the right thigh shows slurring of the upstroke and loss of the reflected wave compared to the left thigh. Augmentation of the plethysmographic tracing at the right calf indicates that the superficial femoral artery is open. The reflected wave is missing in this tracing because of the proximal obstruction. The reflected wave is well preserved in the tracing of the left calf. This figure demonstrates the diagnostic morphologic features of the plethysmographic tracing.



morphology is most accurate. Segmental plethysmography has its disadvantages too. AV shunting in the peripheral circulation, as sometimes seen in liver disease, will cause a dramatic increase in the amplitude of the tracing but will not necessarily change its morphology. The presence of a proximal stenosis, hemodynamically significant only with exercise, may not be detected plethysmographically. The presence or absence of aortoiliac disease associated with superficial femoral disease can usually be read by an appraisal of the upstroke of the plethysmographic tracing. Although we have been very accurate in our predictions, this is a very subjective evaluation, and it is in this area that our highest error rate exists. The error rate would be even higher had amplitude been the only criterion. Some investigators, whose work is described above,<sup>13, 16</sup> have recommended direct puncture of the common femoral artery in this situation, but we have preferred to use instead an analysis of the doppler tracing of the common femoral artery.



**Fig. 2. Doppler Velocity Tracings of the common Femoral Artery**

**A.** Unobstructed arteries showing reversal of flow during diastole.

**B.** Obstruction of the superficial femoral artery showing the break in the down slope of the curve.

**C.** Obstruction proximal to the common femoral artery showing decrease in amplitude and lack of reverse flow during diastole.

**D.** Occlusion of the artery showing a marked decrease in amplitude and in the slope of the upward and downward portion of the tracing.

Nicolaides *et al.* (1976)<sup>23</sup> used a directional doppler coupled with a chart recorder to study blood velocity in arteries such as the femoral artery. A normal arterial signal is triphasic and shows flow reversal in diastole with return to forward flow during late diastole. Obstruction of the artery eliminates flow reversal and outflow obstruction produces a late flattening of the downstroke of the curve (Fig. 2). Using all of the above modalities of

testing, we have only rarely had to resort to femoral arterial puncture.

Exercise may cause a five-fold increase in blood flow to the lower extremity. Lesions not compromising blood flow at rest may compromise blood flow with exercise. For this reason, we add a standard exercise test to the above tests when appropriate to improve accuracy and to document the true physiologic importance of lesions which have been identified.

The use of exercise testing in patients with peripheral arterial disease imposes a certain risk to the patient. Arteriosclerosis is, after all, a systemic disease. At least one death has been reported from exercise testing for vascular diagnosis.<sup>24</sup> Increasing support for EKG monitoring in these patients is appearing in the literature. Carroll *et al.* (1978)<sup>25</sup> studied 81 consecutive patients undergoing treadmill testing as part of a peripheral vascular evaluation. Their testing used a higher per cent grade and a more rapid speed than is our practice, but in all, 11.2 per cent of the tests were stopped prematurely because of EKG abnormalities and an additional 7.5 per cent were stopped because of the clinical appearance of the patient. Some of these patients developed angina on the treadmill. In their patients the number of EKG abnormalities increased from 40.6 per cent at rest to 60.5 per cent with exercise. Premature systoles are not uncommon in exercise testing, however, and often are of no consequence. Cutler *et al.*<sup>26</sup> using the Bruce protocol, again a more strenuous test than our standard, noted that 46 of 100 patients had ventricular dysrhythmia or ischemia documented electrocardiographically. This usually occurred without symptoms. They believed that all patients undergoing evaluation of peripheral arterial disease should at the same time undergo exercise EKG testing, both for patient protection during exercise testing, and because coronary artery disease is one of the leading causes of death following a major vascular reconstruction and should be detected preoperatively.

In discussion of this study, Brewster<sup>27</sup> questioned whether this type of testing was cost effective. Cutler replied that EKG monitoring added approximately \$75.00 to the cost of the study. In neither of the two above studies were there any sequelae of the exercise testing. Both groups would have you believe that this was because of their careful EKG monitoring. We have exercised 210 patients within the past two and one-half years. We have employed EKG monitoring in these patients considered high risk to develop a cardiac

problem. We have been careful not to exercise patients who appeared to be at high risk, and not exercise them beyond the level that occurs in their daily life. In this setting our only detectable adverse effect has been one patient who developed angina during treadmill testing. Since exercise testing in our hands has been benign, we have been reluctant to increase the cost of our testing procedure by adding EKG monitoring and its required physician supervision. When referring physicians have requested cardiac as well as vascular data, we have collaborated with a cardiologist, using his graduated exercise test as the exercise component of the vascular examination.

In spite of the wide popularity of this combination of tests, there have been few studies offering a direct comparison between the results of this type of testing and arteriography. Kempczinski and Rutherford<sup>7</sup> in 1978 documented a correlation of 95 per cent in the aortoiliac system and an accuracy of 97 per cent in diagnosing superficial femoral artery occlusion. The details of this study are not given, and their emphasis in the superficial femoral segment has been on occlusion, which is obviously easier to diagnose than obstruction. They made no comment on their accuracy in the tibioperoneal segment. A similar study was carried out by Rutherford *et al.* in 1979.<sup>28</sup> Although their data are difficult to interpret, they compared arteriography with their vascular laboratory testing in 217 limbs. Their overall accuracy was 97 per cent and no errors were made in normal limbs or limbs with an isolated lesion. As can be seen, our concordance of 96 per cent in the aortoiliac system, 91 per cent in the superficial femoral segment, and 96 per cent in the tibioperoneal segment correspond very nicely to the data reported in the literature, and indicate that this combination of tests is highly accurate compared to arteriography. Because of the noninvasive nature of this testing and the high degree of accuracy achieved and the ability of the vascular laboratory to provide information which supplements that provided by arteriography, the Intersociety Commission for Heart Disease Resources has concluded that a vascular laboratory is desirable in all institutions carrying out arteriography or treating arterial insufficiency. These labs should be able to achieve accuracies similar to the ones reported here. In hospitals where vascular laboratories are used extensively, there has been a profound effect on arteriographic practice. Although the incidence of arteriography has not decreased, the incidence of negative arteriographic studies

has decreased. Patients with physical findings not indicating arteriography have been found to have hemodynamically significant lesions, and then have had arteriography in preparation for surgical repair. Patients with clearly inoperable disease, documented by the vascular laboratory, have been spared an arteriogram. Aggressive use of the vascular laboratory can change the ratio of arteriograms to vascular reconstructive operations from 3:1 to 1:1.<sup>30</sup> It has become increasingly clear that the role of angiography should be to outline the anatomical distribution of arterial disease and not guess its functional significance, or even make the initial diagnosis. Conversely, the purpose of the noninvasive vascular laboratory should be to diagnose the presence of arterial disease and to define<sup>31</sup> physiology rather than to guess at anatomic detail.

Given this degree of reliability, the noninvasive vascular laboratory has many appropriate uses. The noninvasive evaluation of patients with peripheral vascular disease is valuable in selecting patients for arteriography. The vascular laboratory provides additional physiologic information which supplements that provided by arteriography and leads to more accurate identification of significant proximal disease, the most common cause of a failure of a distal reconstruction. Physiologic information has proven highly reliable in predicting the healing of lesions of the foot or the healing of amputations. Followup of patients with known arterial disease or with a previous arterial reconstruction can be carried out on a routine basis using noninvasive testing. Perhaps the most valuable use of the noninvasive laboratory is in the patient who has arterial insufficiency combined with some other disease, such as diabetes or venous stasis, which can produce the same symptoms. In these patients it is possible to determine how much of the patient's symptoms and how much disability is associated with peripheral vascular disease, and how much is caused by something else. Arterial disease can be placed in its proper place relative to other diseases existing in the same patient.

### Summary

The concept of the noninvasive vascular laboratory has become extremely popular in the past few years. Vascular laboratories are proliferating in most of the hospitals in Denver. Our comparison of arteriography in vascular laboratory studies has documented a 96 per cent concordance in the



aortiliac segment, 91 per cent concordance in the superficial femoral segment, and a 96 per cent concordance in the tibioperoneal segment. The vascular laboratory has proven highly accurate not only in identifying patients who have peripheral vascular disease, but also in assessing its physiologic significance. Because of its accuracy, it has proven a valuable adjunct to the arteriogram in the management of peripheral arterial disease. ●

\*Charles O. Brantigan, MD, is Assistant Clinical Professor of Surgery, University of Colorado Medical Center, and at Department of Surgery, Presbyterian Medical Center, Denver, Colorado. Address correspondence and reprint requests to: Charles O. Brantigan, MD, 1839 High Street, Denver, Colorado 80218.

## ACKNOWLEDGEMENTS

This author would like to thank Dr. Sid Stevens of the Radiology Department of Presbyterian Medical Center, Denver, Colorado, for his help in reviewing arteriograms, and Karl Sellar, R.N., for his help in performing many of the studies reported here and for his help with data collection.

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# THANKS FOR HELPING TO KEEP UNITED WAY IN BUSINESS.

Every year, United Way successfully continues to support local human service agencies in communities all across the United States.

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And by operating like any other modern, well-run business enterprise, United Way succeeds in delivering the maximum in human services for the dollars that are collected.

Thanks again for *your* help.





## Denver Task Force Studies Public General Hospitals

The Denver Medical Society Task Force on Public General Hospitals has held more than a dozen meetings in the course of which wide-ranging discussions have been held with representatives of the two hospitals—Denver General Hospital and University Hospital.

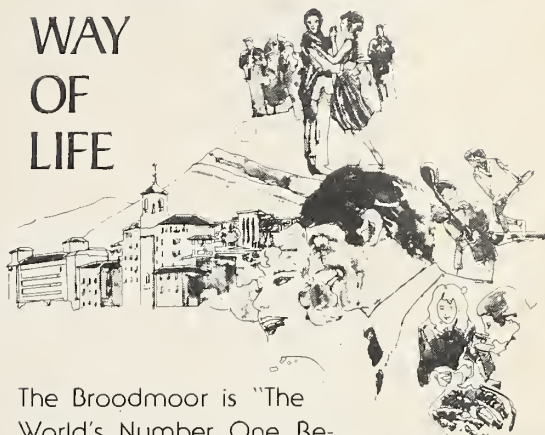
Representatives meeting with this Task Force and related Society committees have included medical students, administrators, house staff, and physicians involved in administration. While primary emphasis has focused on the current status of medical education and research, underlying concerns have necessarily addressed the service aspects of both institutions. The Task Force has also been mindful of the time and attention devoted to these two institutions by the Colorado State Legislature over the past four years. At various times, legislative efforts have been directed toward an understanding of the programs and relationships of the facilities quantitatively and qualitatively. More recent legislative efforts directed toward resolving the problem of providing care for the medically indigent is commonly recognized as having probable major impact on the programs of both institutions.

A document is being developed in an effort by the Denver Medical Society to recommend a course of action that, in the opinion of the Task Force, would benefit both programs, the community at large, and most especially the patients. Findings will be based on the perception of the Task Force of the current realities of program for both hospitals, their relationships to one another and to the private sector of the medical community. The Task Force has attempted to take into account that which is politically feasible, financially cost effective, and consistent with quality medical care. The document, when completed, will be considered by the DMS Commission on Health Care Delivery, the DMS Board of Directors, and the DMS Council.

## ACP Doctors Honored

Four Colorado physicians were honored to be elected as Fellows of the American College of Physicians in May of 1980. They include Thomas M. Hyers, and Gerald S. Kidd II, both of Aurora, John M. Vierling of Denver, and John E. Truell, of Englewood. The Fellows were announced during the 61st annual meeting held in New Orleans in May.

## ENJOY THE BROODMOOR WAY OF LIFE



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# practice management

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## Poor Patient Scheduling — It May Cost You

Are you rushed at the office? Do your patients grumble in the waiting room as your schedule slips behind by 30 minutes, then an hour? Below are some basic tips which may help:

1. Define your patient population
  - Routine - pre-scheduled
  - Urgent - pre-scheduled or walk-in
  - Emergency - walk-in
2. Assess your patient mix and time required to deal with different medical problems
  - Long - 15 minutes
  - Medium - 10 minutes
  - Short - 5 minutes
3. Schedule on the basis of each hour. Leave 20-30 minutes unscheduled at the end of the hour for over-runs or work-ins.
4. Start on time.

These are basics. If you have practice patterns that suggest a problem, send yourself or someone in the office to a practice management seminar. These problems can devastate an office. They cost you patient satisfaction and money. As an example, a physician was recently billed \$75.00 by another professional for time wasted in the waiting room. The physician also lost future business from the patient. Scheduling is important.

## CME Records File Received by CMS Members

A blue and white continuing medical education (CME) records file should have arrived at most Colorado Physicians' offices about August 15th. The file has been provided by CMS as a service for member physicians to assist them in recording their CME hours. The file contains printed suggestions for use as well as a summary of the Board of Medical Examiners regulations governing CME requirements for relicensure.

Members who have not received a CME record file or are not sure how to use it, may call the Division of Continuing Education at 861-1221 x 262 (or toll-free outside the Denver metro area at 1-800-332-4150 x 262).

## Ex-Patient Commends Physician

June 15, 1980

Mr. Brian Stutheit  
Colorado Medical Society  
1601 E. 19th Avenue  
Denver, Colorado 80219

RE: Dr. R.H. Altmix  
Hampden Medical Group  
221 E. Hampden Ave.  
Englewood, Colo. 80110

Dear Mr. Stutheit:

I wish to commend for your information the above named physician.

Your records may or may not show that Dr. Altmix suffered a stroke some two years ago, and has not been in practice since that time. Dr. Altmix was the family physician for over thirty years, and was always quick to recognize a problem and medicate or advise for the most satisfactory conclusion.

Last March, I fainted and my daughter, not knowing whom to call, called Dr. Altmix at his home. . . . He of course very wisely told her to call the fire department. The rescue squad of course took me to Swedish.

The real show of concern was that Dr. Altmix found someone to drive him to Swedish emergency room, and he dragged himself in to offer assistance. He of course very wisely turned me over to another physician.

With the medical profession being in real trouble and held up to so much criticism, if more doctors would take a page from the book of Dr. Altmix better feelings would result.

The future medical practice of Dr. Altmix is of course very uncertain, but I did want your Society to hear something good for a change.

Yours truly,

Arthur W. Hill  
1474 W. Parkhill Ave.  
Littleton, Colo. 80120



## **THE ARVADA MEDICAL CENTER**

Located in the heart of Arvada at 8859 Ralston Road has a retail space and two medical suites now available for lease.

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### **MEDICAL SUITES**

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606 square foot suite consisting of a business and reception area. Consultation office, two examination rooms, small lab and a private restroom. Rent is \$430/month.

## **THE ARVADA MEDICAL CENTER**

has excellent visibility, good identity and an excellent reputation. The Arvada Medical Center is on the RTD busline, has good off-street parking and a wheelchair ramp to provide easy access when needed. Common area waiting lounges are tastefully decorated with hanging plants, rich wood paneling, paintings, metal sculptures, skylights, fine carpeting and custom-designed furniture. For an appointment to see these suites, call MR. BOB LEINO (owner) at FULLER AND COMPANY — 292-3700.

## FIRST ANNUAL "ROBERT L. PERKIN MEDIA AWARDS FOR MEDICAL REPORTING"

A panel of judges has announced its decision of winners in the first annual "Robert L. Perkin Media Awards for Medical Reporting." Judges in this first state-wide competition, sponsored by the Colorado Medical Society, were: Thomas M. Vernon, MD, Assistant Director, Colorado Department of Health and a member of the CMS Council on Public Health, Sam Archibald, Associate Professor of Journalism, University of Colorado, Stewart Perlmet, Technical Director-Producer, University of Colorado Health Sciences Center Department of Biomedics, and Robert A. O'Dell, MD, Chairman, Public Information Committee, Colorado Medical Society.

Awards were given, based on the technical information presentation, technical production of the story or the feature series, ability of the reporter to convey the message in a factual but engaging journalistic manner, quality of photography (where photography was judged to be an integral part of the report), and the timeliness of the story.

There were two categories of stories in the competition: Spot News (meaning news stories which were immediate and were being produced in keeping with a daily or established deadline), and Feature Reports (one of a continuing series concerning a single subject).

Judges considered the entries from three sources: radio, television and newspaper--periodicals. The first yearly competition produced 28 entries representing all three areas of reporting. The following are the winners:

Newspaper Feature Reports: First Place to Pamela Avery, Rocky Mountain News. "'80s Seen As A Golden Age In Disease Work."

Newspaper Feature Reports: Second Place to Pamela Avery, Rocky Mountain News. "What's Up Doc?....Health Care Costs."

Newspaper Spot News: First place to Louis Kilzer, Rocky Mountain News. "Vipoint.....Compound X."

Newspaper Spot News: Second place to Bill Symons, The Denver Post. "Transplant of Kidney Links Brother, Sister."

Television Feature Reports: First place to Jim West, KOA-TV News, Denver. "Reyes Syndrome."

Television Feature Reports: Second place to Burt Gurule', KMGH-TV News, Denver. "Children's Burns."

Television Spot News: First place to Sharon Wright, KMGH-TV News, Denver. "Toxic Shock Syndrome."

Television Spot News: Second Place to Sharon Wright, KMGH-TV News, Denver. "Violence In Mental Health."

Radio Feature Reports: No award given

Radio Spot News: No award given

Presentation of the awards will be made by the Officers and Trustees of the Colorado Medical Society at its Annual Session of the House of Delegates, September 23-27, 1980, at the Broadmoor Hotel in Colorado Springs.



# CONTINUING MEDICAL EDUCATION

# CALENDAR

PUBLISHED JOINTLY BY THE COLORADO FOUNDATION FOR MEDICAL CARE, COLORADO MEDICAL SOCIETY AND THE COLORADO ACADEMY OF FAMILY PHYSICIANS • 1601 EAST NINETEENTH AVENUE, DENVER, COLORADO 80218

## SEPTEMBER 1980

### 14th-18th

**HOSPITAL MEDICAL STAFF CONFERENCE AND HOSPITAL TRUSTEE FORUM.** Estes Park. Contact: Estes Park Institute, P.O. Box 400, Englewood, CO 80151. 761-7709.

### 15th-18th

**PULMONARY MEDICINE - 1980: AN UPDATE FOR THE CLINICIAN.** Vail. Contact: Dale E. Braddy, Director of Education, American College of Chest Physicians, 811 Busse Highway, Park Ridge, IL 60068. (20 hours of AMA Category 1 credit).

### 21st-24th

**VASCULAR SURGERY.** Denver. Contact: Office of Postgraduate Medical Education, University of Colorado Health Sciences Center, 4200 E. 9th Ave., C-295, Denver 80262. 394-5241.

### 22nd-24th

**5TH ANNUAL VASCULAR SURGERY SYMPOSIUM.** Brown Palace Hotel, Denver. Contact: Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 E. 9th Ave., C-295, Denver, CO 80262. 394-5241. (18 hours of Category 1 AMA credit).

### 24th

**COLORADO REGIONAL NEURORADIOLOGY & COMPUTERIZED TOMOGRAPHY MEETING.** Department of Radiology, St. Luke's Hospital, Denver. Contact: Leatha Kibel, 394-7773. (3 hours of AMA Category 1 credit).

### 24th-27th

**110TH ANNUAL SESSION: COLORADO MEDICAL SOCIETY.** Broadmoor Hotel, Colorado Springs. Contact: Virginia Bell, Colorado Medical Society, 1601 E. 19th Avenue, Denver, CO 80218. 861-1221, ext. 247.

### 25th

**THROMBOEMBOLISM AND THROMBOLYTIC THERAPY.** Denison Auditorium, University of Colorado School of Medicine, Denver. Contact: Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 E. 9th Ave., C-295, Denver, CO 80262. 394-5241.

### 25th-26th

**THE RELATION OF ENVIRONMENTAL POLLUTION TO THE CANCER PROBLEM IN COLORADO.** AMC Cancer Research Center and Hospital, Lakewood. Contact: AMC Cancer Research Center and Hospital, 6401 W. Colfax Ave., Lakewood, CO 80214. 233-6501, ext. 209.

### 26th-27th

**9TH ANNUAL MONTROSE FALL CLINICS.** Montrose, CO. Contact: Kathy Holman, Montrose Memorial Hospital, 800 S. Third St., Montrose, CO 81401. 249-2211. (10 hours of AMA Category 1 credit).

### 27th

**CARDIOLOGY: DIAGNOSIS & SURGERY.** The Broadmoor, Colorado Springs. Contact: Barbara Porter, American Association of Medical Assistants, 6825 Cliff Palace, Colorado Springs, Colorado 80911. (6 hours CEU).

## OCTOBER 1980

### 2nd

**ASSOCIATION OF PLANNED PARENTHOOD PHYSICIANS POSTGRADUATE PROGRAM.** Denver Hilton. Contact: Association of Planned Parenthood Physicians, 810 7th Ave., New York 10019. (404) 329-3131. (6 prescribed hours of AAFP credit).

### 2nd

**NEUROPSYCHIATRIC GRAND ROUNDS.** Colorado State Hospital, Pueblo. Contact: Jay Scully, M.D., 1600 W. 24th Street, Pueblo, CO 81003. 543-1170. (APA approved for Category 1 credit).

### 12th-18th

**POSTGRADUATE COURSE ON CLINICAL MANAGEMENT & CONTROL OF TUBERCULOSIS.** National Jewish Hospital, Denver. Contact: Paul T. Davidson, M.D., Department of Medicine, National Jewish Hospital & Research Center, 3800 E. Colfax Ave., Denver 80206. (48 hours of AMA Category 1 credit; 48 prescribed AAFP hours; 48 Colorado Nurses Association contact hours).

### 13th-18th

**26TH ANNUAL FAMILY PRACTICE REVIEW.** Denver. Contact: Office of Postgraduate Medical Education, University of Colorado Health Sciences Center, 4200 E. 9th Avenue, Denver, CO 80262. 394-5241.

### 15th

**CARDIOLOGY UPDATE FOR THE FAMILY PRACTITIONER.** 6th Floor Classroom, St. Joseph's Hospital, Denver. Contact: Mary Jean Berg. 837-7598. (8 prescribed hours of AAFP credit).

### 22nd

**COMMON PROBLEMS IN PEDIATRIC PRACTICE.** Julesburg, CO. Contact: Martin J. Rubinowitz, M.D., The Denver Clinic, 701 E. Colfax Avenue, Denver, CO 80203. (AMA Category 1 credit and AAFP prescribed credit).

## 22nd

**REGIONAL COMPUTERIZED TOMOGRAPHY/NEURORADIOLOGY/ULTRASOUND CONFERENCE.** St. Joseph's Hospital, Denver. Contact: Leatha Kibel. 394-7773. (3 hours of AMA Category 1 credit).

## NOVEMBER 1980

### 3rd-8th

**DENVER POSTGRADUATE INSTITUTE IN EMERGENCY MEDICINE.** Denver General Hospital. Contact: Peter D. Bryson, M.D., Denver General Hospital, West 8th Avenue & Cherokee, Denver, CO 80204. 893-7034.

### 6th

**NEUROPSYCHIATRIC GRAND ROUNDS.** Colorado State Hospital, Pueblo. Contact: Jay Scully, M.D., 1600 W. 24th Street, Pueblo, CO 81003. 543-1170. (APA approved for Category 1 credit).

### 12th

**REGIONAL COMPUTERIZED TOMOGRAPHY/NEURORADIOLOGY/ULTRASOUND CONFERENCE.** University Hospital, Denver. Contact: Leatha Kibel. 394-7773. (3 hours of AMA Category 1 credit).

## AMA Receives Golden Trumpet Award

The AMA will receive a "Golden Trumpet Award" for its membership recruitment and retention campaign. The award from the Publicity Club of Chicago cites a 16-mm film titled "What is the AMA? The AMA is You"; a membership kit called "Organized Medicine Working for You"; *AMA Highlights*, a biweekly newsletter geared to promote membership; *Federation Membership News*, which shares recruitment tips with state and county medical society executives; and a mobile van unit which brought information on Association activities to the field.

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## 14th-16th

**4TH NATIONAL CONFERENCE ON JOINT PRACTICE.** Brown Palace Hotel, Denver. Contact: William B. Schaffrath, Ph.D., The National Joint Practice Commission, 35 E. Wacker Dr., Suite 1990, Chicago, IL 60601. (312) 236-8920.

## DECEMBER 1980

### 4th

**NEUROPSYCHIATRIC GRAND ROUNDS.** Colorado State Hospital, Pueblo. Contact: Jay Scully, M.D., 1600 W. 24th Street, Pueblo, CO 81003. 543-1170. (APA approved for Category 1 credit).

### 11th-13th

**THE MANAGEMENT OF PATIENTS WITH BURN INJURIES.** Hilton Hotel, Denver. Contact: John A. Boswick, Jr., M.D., 4200 E. 9th Avenue, Box C-309, Denver, CO 80262. 394-8718. (18 hours of AMA Category 1 credit).

### 17th

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## AMA Takes Stand On Marijuana Legislation

A proposed amendment to marijuana legislation now before Congress, which would maintain existing criminal penalties for simple possession, may be too extreme, the AMA told the Senate Judiciary Committee. In a previous statement to the House Judiciary Committee, the AMA urged Congress to be "especially careful not to convey to young people and their parents the message that society now sanctions marijuana use." However, the Association expressed concern over "the stigma that any period of imprisonment or a felony conviction attaches to a young person's record and the lifelong barriers to many avenues of employment and other future development that may result from sporadic use of marijuana or even a moment of youthful misdirection." The AMA called for a middleground treatment of people found guilty of simple possession of marijuana and for severe penalties for those who traffic in the illicit marketing of controlled substances, including marijuana.



# Environmental radiation concerns in perspective

D.C. Hunt, PhD, and T.R. Crites, PhD, MPH, Golden, Colorado

## *Natural Radiation in the Environment*

We are all radioactive to a measurable extent and live in a world which contains a number of radioactive elements (about 70) distributed around us in the air, water, and soil. Several excellent references exist on the quantities of radioactive materials which are found in the environment; from text books<sup>1</sup> to reports by special study groups.<sup>2,3</sup>

The soil contains many of the heavier natural radioisotopes, such as uranium, thorium, and radium. Even plutonium is found in nature due to spontaneous fission neutron interactions in uranium deposits. Isotopes of these elements are generally alpha emitters which may be deposited in the body through inhalation of resuspended dust and gaseous decay products or ingestion. Average lung doses of 100 mrem/yr due to these alpha emitters are typical, with some lung regions receiving much higher doses.<sup>3</sup> These materials also are generally present in water supplies where concentrations may vary by several orders of magnitude. Radium-226 intake from this source alone may reach 90 pCi per day. Potassium-40, a naturally occurring beta emitter, is readily incorporated into body tissue. The typical person contains 0.1 Ci and receives a yearly gonadal dose of 19 mrem from this isotope.

Radioisotopes are continuously produced in nature through the interaction of cosmic rays with atmospheric nuclei. Tritium and carbon-14 are two which are incorporated into human tissue and can be measured in natural systems.

Radioactive materials in the environment also contribute to external exposures. Combined with the radiation exposure we receive from cosmic rays, these amount to from 70 to 175 mrem/yr in the United States. Variations exist due to differences in altitude, the mineral content of soil and the living conditions of area residents. Though radiation exposures to significant population groups could be cut in half by geographic relocation, no one has yet suggested this to be a worthwhile change.

## *Man Made Environmental Sources of Radiation*

While natural background radioactivity contributes significantly to the average person's radiation dose, nearly half of the total expected exposure originates from the activities of man. Weapons testing fallout, mining activities, burning of fossil fuel, nuclear facility operation, medical procedures, and certain consumer products all contribute to this exposure. These will be considered individually as follows:

1. Weapons Testing Fallout - Since nuclear weapons testing commenced in 1945, some 801 nuclear detonations have been announced by six countries with a total yield of about 325 megatons.<sup>4</sup> Of these detonations, approximately 270 megatons have been exploded in the atmosphere hence making the associated fallout directly available environmentally. Most of the environmental fallout injection ceased 17 years ago with signing of the limited test ban treaty.

A number of materials are environmentally introduced by nuclear detonations. These include a wide variety of radioactive fission products (of which <sup>90</sup>Sr and <sup>137</sup>Cs are perhaps of the most concern) and also unburned uranium and/or plutonium. It is estimated<sup>5</sup> that seven tons of plutonium have been released into the atmosphere from weapons testing and further that about 0.25 gram of this plutonium has been ingested or inhaled by the world's population. This results in an estimated population dose<sup>6</sup> equal to between 0.1% and 2% of the natural background total.

2. Mining - All mining operations have the potential for enhancing environmental radiation levels by bringing to the surface materials with elevated radioactivity levels. Phosphate mining in Florida, as an example, brings to the surface rock whose total alpha activity is 200pCi/g<sup>7</sup> compared to 4 pCi/g activity in typical environmental rock samples.<sup>1</sup> Uranium mining is the activity

which brings to the surface material of the highest specific natural alpha activity. These are typically 5,000 pCi/gram of ore or 12,500 times usual environmental alpha activities. The mining operations themselves emit levels of radon ranging from 0.5 to 20  $\mu$ Ci/min/1000 ft<sup>3</sup> of air exhausted from the mine. These levels of radon emission are equivalent to the natural emissions from about 0.2 km<sup>2</sup> of the earth's surface.<sup>1</sup> Additionally the mills at which the ores are concentrated generate tailings piles and settling ponds containing uranium related radioactivity. Current practice is to stabilize tailings piles with topsoil and plantings and to line settling ponds. Lack of such precautions in the past has led to radium activity in waterways near mills of 10 to 100 times normal environmental levels and airborne radon levels near tailings piles which approach permitted environmental concentrations.

3. Fossil Fuel Consumption - The use of natural resources frequently increases the availability of radioactive materials in man's environment. Coal fired plants release millions of  $\mu$ Ci's of alpha emitting radionuclides each year (290 million of uranium-238 and 250 million of thorium-232 in 1976) and give rise to annual fence line exposures comparable to existing nuclear power plants. Bone doses are estimated<sup>8</sup> to be even higher. The use of natural gas for cooking causes doses to parts of the lung from 2 to 9 mrem/yr due to radon gas.<sup>9</sup>

4. Nuclear - Emissions of radionuclides from nuclear facilities such as nuclear electrical generating stations or plants like Rocky Flats which handle nuclear materials are carefully monitored, reported, and controlled. Estimates<sup>10</sup> of radiation to the general public from nuclear power plant operation are .03 mrem/year whole body dose or about .015% of the natural background radiation for persons in the Denver area. Even for the infamous Three Mile Island reactor accident, the average whole body dose to those living within 50 miles of that plant was 1.5 mrem or 0.75% of the background dose (less difference than a two week vacation to Denver for those involved). Plants such as Rocky Flats also contribute negligibly small radiation levels to the surrounding areas. Estimates from the most recent Rocky Flats Monitoring Report<sup>11</sup> show a maximum probable site boundary bone dose of 1.2 mrem. This is 0.71% of the area background bone dose level. Hence, while the potential ex-

ists for accidents which would lead to exposures approximately equivalent to annual natural radiation doses, the current "track record" of nuclear facilities has been exceptionally good with regard to environmental exposures of populations in surrounding areas.

5. Medical - The medical use of radioactive isotopes also introduces a potential for exposure to members of the general public. Though the consequences of dose to individual patients is considered justified in the patient's treatment, their excreta and the disposal of these medicines by hospitals or clinics increases the quantity of radioactive material in the environment. Monthly use rates of one million  $\mu$ Ci of iodine-131 and eight to nine million  $\mu$ Ci of technetium-99m have been reported for a single hospital.<sup>12</sup> Current practice is to release a patient from control while still containing thousands of  $\mu$ Ci's of activity.<sup>13, 14</sup> Individually, these isotopes are generally less radiotoxic than some of the longer lived isotopes. The medical exposures contributed to the general public give rise to concern over the adequacy of their control.<sup>15</sup> The EPA has estimated an average radiation dose of 75 mrem per year per person due to medical sources.

6. Consumer Products<sup>9</sup> - Advancing technology has led to the incorporation of radioactive materials into a number of products generally available to the public. Hundreds of  $\mu$ Ci's of tritium and tens of  $\mu$ Ci's of promethium-147 are incorporated into individual wrist watches to provide illumination. Emergency exit signs may contain as much as three million  $\mu$ Ci's of tritium each. The disastrous use of radium for similar purposes has ceased, but some radium dials still remain. Smoke detectors commonly contain several  $\mu$ Ci's of the alpha emitter americium-241 and commercial units contain an average of 50  $\mu$ Ci's each. This material is involved in fires at a greater annual rate than the Rocky Flat Plant emits the less radiotoxic plutonium. Use of radioisotopes in such diverse products as static eliminators, depth gauges, well logging, radiography, etc., have become so common that many people don't even realize their presence.

## **Monitoring**

Radionuclide monitoring is performed extensively on scales ranging from global to local. The monitoring of worldwide weapons test fallout



has been done by the Department of Energy's Environmental Measurements Laboratory (EML) since 1954. As an example, global  $^{90}\text{Sr}$  deposition and concentration in precipitation has been monitored since 1954 at 77 land and ocean sites. Air sampling for 12 radionuclides (including  $^{238}\text{Pu}$  and  $^{239}\text{Pu}$ ) at 51 stations worldwide (including up to four stations near the Rocky Flats Plant) has occurred since 1963. Other routine surveillance operations include analysis of milk and tap water at several U.S. locations. Results from these programs are given in EML Reports.<sup>16</sup>

Nationwide, environmental radionuclide surveillance is currently performed by the U.S. Environmental Protection Agency (USEPA). The USEPA conducts special surveillance activities such as the determination of environmental plutonium levels near the Trinity Test Site<sup>17</sup> and measurement of radionuclides in cattle near the Nevada Test Site.<sup>18</sup> The major USEPA routine surveillance activity for radionuclides is in the Environmental Radiation Ambient Monitoring System (ERAMS). This was established in 1973 by the USEPA Office of Radiation Programs (ORP) and provides country-wide measurements of radionuclides in air and water as well as ambient gamma level determinations. Airborne plutonium and uranium levels are determined at 22 sampling stations. Fifty-eight surface water sampling stations (either background or near nuclear facilities) measure tritium and total gamma levels, while drinking water samples are obtained from 78 sites. These results are given in a series of USEPA-ORP Reports.<sup>19</sup>

Within Colorado, the general radionuclide environmental monitoring is done by the Colorado Department of Health (CDH). Monitoring near nuclear facilities and operations such as the Fort St. Vrain Nuclear Generating Station or the Rocky Flats Plant is performed by the facility operators with confirmatory surveillance supplied by CDH and in a few cases by County Health Departments. In the case of the Rocky Flats Plant, these monitoring results are presented monthly at public "data exchange meetings" and reported in associated surveillance documents.<sup>20, 21</sup>

### ***Controlling***

Numerous organizations exist for the control of radioactive emission to the environment. The Nuclear Regulatory Commission (NRC) has enacted legislation for the regulation of commercial (licensed) activities. The Department of Energy regulates the limits on its contractors.

The EPA has recently been promulgating national requirements in air, water, and soil radioactivity. In the past, agencies such as the Public Health Service, Federal Radiation Council, NCRP, etc., have been involved. Additionally State and local governing bodies may enact requirements of their own.

Operators of nuclear facilities are in a position to control their release of radioactive material to the environment and so are carefully regulated. Controls on ventilation (filtration), water processes, and operations are used along with sophisticated monitoring equipment to provide assurances of minimal environmental impact. Based on a zero risk approach, these emissions have been reduced to the point that they now contribute considerably less dose to the population than other similar radiations in nature.<sup>22</sup> Regulations on where people live, their type of housing, etc., could now have a greater effect on reducing population exposure than additional controls on nuclear operations.

Control of radiation dose due to the natural environment, even though offering greater dose reduction, may not be desirable. Likewise, the expenditure of funds to reduce further nuclear plant emissions so far below the natural background may offer no health benefit.

### ***Comparative Aspects of Radiation Risks***

Estimates of Sagan<sup>10</sup> (from calculations made by Professor Ralph Lapp based on BEIR Committee results) indicate that of the approximately 400,000 cancer cases and 350,000 genetic effects expected each year from all causes, about 1.5% and 0.1% respectively would be radiation induced. The radiation induced health effects may then be further broken down into numbers of health effects due to radiation exposures from various sources. Thus 51% of those genetic effects and cases of cancer thought to be radiation induced would be associated with natural background radiation, 43.3% with medical diagnostic procedures and 5.7% with other causes. The other causes include 2.5% from technologically enhanced (e.g., burning coal, mining phosphates) radiation and 3.2% from fallout, nuclear power generation, and nuclear facility operation. On a probability basis then, an individual's annual chance of experiencing a somatic health effect as a result of exposure to weapon's testing fallout, nuclear power generation, or nuclear facility operation is 7.1 out of 10,000,000 and their chance of genetic effect is 4.7 out of 100,000,000.

One other interesting comparison can be made, namely a specification of the actual health effect causing potential of plutonium in relation to other common carcinogenic environmental pollutants. This is done by (1) determining the ratio of the estimated environmental emissions of the pollutants<sup>23</sup> in question to that of plutonium and (2) dividing this by the ratio of the amount of pollutant permitted in water or air<sup>24</sup> to that permitted for plutonium. This was done for eight materials - selenium, chromium, benzo- $\alpha$ -pyrene (BAP), arsenic, asbestos, nickel, vanadium, and cadmium. The results show that all eight pollutants are much more of an environmental threat than plutonium. The relative threat values for airborne material ranged from  $4.8 \times 10^7$  for BAP to 79 for cadmium with an average of  $6.26 \times 10^6$  (i.e., they are six million times more threat than plutonium). The corresponding relative health effect values for waterborne material ranged from  $2.86 \times 10^6$  for cadmium to  $7.69 \times 10^7$  for chromium with an average of  $5.16 \times 10^7$ . Additionally many of these materials have an infinite environmental half-life.

## Summary

We live in a sea of radiation, most of which is either natural background or due to medical therapeutic and diagnostic procedures. This amount of radiation contributes a very small (2 chances in 100,000 per year) health effect risk compared to other commonly accepted hazards of everyday life (20 in 100,000 per year auto fatality, 100 in 100,000 per year tobacco smoking deaths). A disproportionate amount of money, time, and effort has none-the-less been spent on attempting to monitor and control man-made radiation sources. As an example<sup>25</sup> this country is planning now to spend \$200,000,000 per fatality averted on the containment of high level defense related nuclear waste while spending \$75,000 per fatality averted for hypertension control or \$70,000 per fatality averted in lung cancer screening and care. At a time when we are beginning to learn the limits of our national resources, it is necessary to increase the sense of perspective brought to environmental radiation. ●

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# Adoption of Children

This article outlines the statutory prerequisites to adoption in Colorado. Except in very limited circumstances involving succession to an estate, the statute affords the only legal method of adoption. Keep in mind that the criteria for who may adopt and availability for adoption are baseline minimums. People petitioning to adopt a child will still face evaluation of financial well-being, morals, and other considerations for the child's good. As the Colorado Supreme Court once stated, adoption laws were drafted as an attempt to reconcile the right to custody of their own children which nature gives to parents with the *primary consideration* of the welfare of the child. (Emphasis added.)

## *Who May Adopt:*

- a) A person over the age twenty-one
- b) A minor, with court approval
- c) Spouses who are not legally separated and desire to adopt a child must petition jointly
- d) If one petitioning spouse is already the natural parent, then only the other spouse needs to petition for adoption.

## *Availability and Methods for Adoption:*

A child present in the state at the time of a petition for adoption must be "available" as defined in the law. A roughly stated prerequisite is that a court must verify that any pre-existing parental relationship has terminated. Termination may result from many methods under varied circumstances. Some other interesting specifics include:

- a) Placement of a child cannot be arranged outside Colorado unless the department of social services has verified that the placement agency is licensed or authorized by the laws of the other state and that any custody was obtained legally.
- b) Children twelve years of age or older must make written consent to a proposed adoption.
- c) A minor parent may give consent to the adoption of the natural child.

There are legal provisions which seem to have been aimed at the "grey market" in babies. People may not offer, give, charge or receive any money or other thing of value in connection with a consent to adoption or with a petition to adoption. (C.R.S. 1973, 19-4-115.) No placement for adoption may be made by anyone other than the court, the county department of social services,

a licensed child placement agency or an individual in whom the court has placed legal guardianship. (C.R.S. 1973, 19-4-108.) This is reinforced by a law prohibiting placement of a child in a home, other than with relatives, by anyone not licensed as a child placement agency. (C.R.S. 1973, 26-6-104.)

Additionally, Colorado has signed the Interstate Compact on Placement of Children (C.R.S. 1973, 24-60-180, 1875 Supp.) In Colorado, Milton Hanson of the Department of Social Services has been designated the administrator who coordinates activities under the Compact. Only five states are not Compact members. They are Hawaii, Michigan, Nevada, New Jersey, and South Carolina.

Signatories to the Compact are bound to give the other states notice of transfer of a child as a preliminary to adoption. Persons wishing to place a Colorado child in another state must first receive approval of the Colorado Compact administrator.

Signatories to the Compact also agree not to send a child across state lines, or to bring one in, unless the applicable laws of the receiving state are complied with.

**Brian K. Stutheit**  
**Director, Division of Professional and Patient Relations**

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### THE COVER

K. Mason Howard, M.D., of Arapahoe County Medical Society is the newly-installed President of Colorado Medical Society. Dr. Howard is, of course, already familiar to many of you throughout Colorado, and he hopes to become acquainted with every member of CMS. You'll be hearing, regularly, from the President's office through his monthly President's Letter as well as his visits to component society and specialty society meetings throughout the coming year. (Note: See President's Letter, p. 344, and President's Challenge for the '80s, "At Press Time").

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Julie Felix, Editorial and Production Assistant  
Lambda Graphics, Typography & Layout

*Colorado Medicine* (ISSN-0199-7343) is published monthly for \$12 per year by the Colorado Medical Society, 1601 East 19th Avenue, Denver, Colorado 80218. Second-class postage paid at Denver, Colorado. POSTMASTER: Send address changes to *Colorado Medicine*, 1601 East 19th Avenue, Denver, Colorado 80218.

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# president's letter

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It is October, 1980, and we all realize that another year has dwindled preciously close to exhaustion. For whatever resolutions we made in the previous year we have little time left to bring them to pass; we have just completed another Annual Session during which the House of Delegates received many new, proposed resolutions, ostensibly to be carried out during the coming year.



The annual President's Planning Session was held in early September, at which time a statement of purpose and list of goals were hammered out, based on staff research and on the priorities placed on the related programs by physician-members of the Colorado Medical Society. There was a strong thread of continuity woven throughout the ten major areas of concentration; that theme is COMMUNICATIONS . . . communications, principally, among members and component organizations of CMS, between CMS components and specialty societies, between CMS members and allied health professionals, between CMA members and their elected Association officers, and between physicians and the general public.

The 1980 President's Planning Session did a number of things for me as I assumed the new office: first, the meeting gave me considerable insight into the attitudes and the concerns of the CMS leadership and general membership; second, this session helped establish in my mind the methods by which the Colorado Medical Society can accomplish considerable good for its members and for the public at large; third, the planning session developed a program of purpose and goals which can be carried on from one association year to the next, with little disruption because of a change in the elected administration; fourth, the program priorities expressed by the 1980 President's Planning Session showed me a singleness of purpose which has not always been paramount in this organization. This commonality of thought and purpose provides me with a very realizable goal for the coming year.

I plan to implement your programs to the best of my ability and the ability of our budget to cover the costs. We have had an excellent and a

highly productive year under the leadership of Ray Witham. Our planning will enable the Societies to carry on with the strong alliances and the positive strides made by Ray and the Society staff during the year.

There is, however, one condition: communication is a two-way street! You must communicate with your CMS officers and staff. You must make your feelings and your wishes known, in order that the Society may best serve your professional and personal interests.

Let's start immediately to activate these new association purposes and goals. Let me hear from you . . . now!

Respectfully,

K. Mason Howard

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## practice management

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### Negotiations with Blue Cross/ Blue Shield

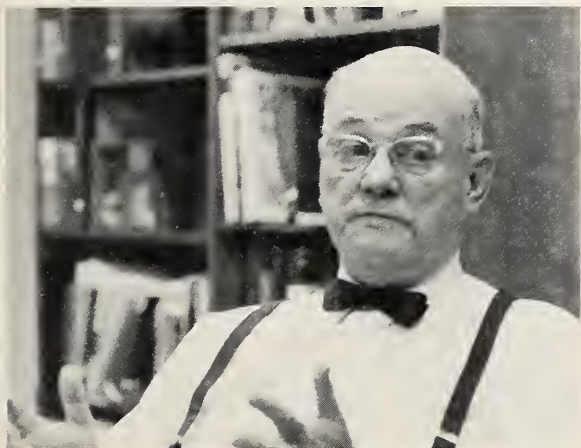
The special committee for negotiations with Blue Cross/Blue Shield (now known as the Rocky Mountain Hospital and Medical Service Corporation) is engaged in productive talks which center on the following issues:

1. Public relations messages which may polarize physicians and Blue Cross/Blue Shield.
  2. Administrative response mechanism used by Blue Cross/Blue Shield.
  3. Physician practice management difficulties.
  4. Patient and Physician education required in the reimbursement system.
  5. Cost effective coverage which is, or may be offered.
- \* Each issue represents a concern expressed throughout the state. Initially, the CMS will work to change messages which may confuse patients and reflect poorly on Physicians.



# THE PINK SHEET

## Ward Darley, M.D.— An Appreciation



The Colorado Consortium for Continuing Medical Education recently began to publish the PINK SHEET, a newsletter for Colorado continuing medical educators. That's a strange name for a newsletter—unless you know that the title evokes the memory of Dr. Ward Darley, former Dean of the University of Colorado School of Medicine and President of the University.

In the late 1960's, having retired as Executive Director of the Association of American Medical Colleges, Ward was working with me and the Western Interstate Commission for Higher Education on a plan for medical education in the sparsely settled states of Idaho, Montana, Nevada and Wyoming. The published version of the plan had pink covers. Ward always referred to it as "... the report between the pink covers." The report talked about how states that had always been out of the main stream of academic medicine could hope to create, inside their own borders, new institutions that would bring medical education and research within the walls of their hospitals and universities. The plan was part of Ward's persistent search for ways to bring the best of medical care to the smallest of communities.

His concern about quality of life in remote communities was surely inherited. His grandfather, Rev. George Darley, traveled the San Juan mountains in the late 1800's, bringing religious services to the people in communities like Ouray, Silverton and Lake City.

It was always a pleasure to work with Ward Darley. He had a marvelously satisfying ability to make the young researcher or physician or administrator feel that Ward really needed and valued his ideas. In his last years, Ward lived on the West Coast and came to Denver once or twice a year. When he arrived, my phone would ring, and I would go to his apartment to have my brain picked by this incredibly alert young mind in a tired and hurting body. He wanted to know what I thought about how the SEARCH program was going; who the educational leaders were in Durango, La Junta or Grand Junction; and how the Medical School was doing with its educational outreach program.

one of the greatest medical educators of this century, cared about what I thought. Those treasured meetings always ended with his giving ideas to me—almost frenetically, as though he knew there wouldn't be time to talk out all the plans and proposals that were teeming in his mind. He was planting seeds in me hoping some would grow and eventually help to fill in his vision of the future of health care.

For me, Ward Darley was a hero; not a remote and idealized man, but an accessible hero who gave me a guiding hand for a while.

The PINK SHEET is for continuing medical educators who want to keep up with what's going on in their field. It is one small effort to improve the practice of health care in Colorado, and a reminder of Ward Darley's indelible contributions to medical education and practice.

**Kevin P. Bunnell**  
Executive Director,  
Colorado Consortium for  
Continuing Medical Education

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The "Pink Sheet" is printed and distributed every other month by the Division of CME. If you wish to be added to the mailing list, which already has a substantial number included, call CMS, 861-1221, extension 262.

## Minors, Consent To Health Care

This area of law has grown extensively in the past few years. The United States Supreme Court has affirmed that mature minors may consent to abortions and the receipt of contraceptives without interference from a third-party (often a parent). This right to consent is based on a constitutional right to privacy legally inherent in the childbearing process.

In Colorado, persons eighteen years of age or older are competent to consent to hospital, medical or dental care to the full extent allowed any other adult person. C.R.S. 1973, 13-22-103 (1979 Supp.) amending 13-22-103 (1973). A minor fifteen years of age or older who is living apart from his parents or guardians and is managing his own financial affairs may consent, as an adult, to medical, dental and emergency health services. This same right to consent is vested in any minor who has contracted a legal marriage. A physician who, in good faith, provides service to persons of the last two categories is immune from civil damages for failure to contact such persons' parents.

A minor parent may consent to the provision of medical services for his child. When such consent is given, that minor parent has the same rights, powers, and obligations as if he were of legal age.

A parent who withholds his or her consent to medical services where the life of his or her child is threatened must be taken to court by the physician, the hospital or some other "friend of the child." The Court, as evidenced by several cases, will usually take the side of the child and the lack of parental consent will be disregarded. See, e.g., *Jehovah's Witnesses v. King County Hospital*, 278 F. Supp. 488 (W.D. Wash. 1967) aff'd 390 U.S. 598 (1968).

In a true emergency situation, the physician may act to save a minor and receive immunity for his unconsented-to activity through the Colorado Good Samaritan statute, provided that the patient does not protest treatment. Nonetheless, the physician should make some reasonable effort to contact the parent first.

Under Colorado law, a physician may treat a minor patient for addiction to or use of drugs without consent by or notice to the parents. C.R.S. 1973, 13-22-102.

Minor victims of sexual assault may be treated upon their own consent for immediate conditions caused by the assault, but physicians operating under this law must make a reasonable effort to notify the parents or guardians of the as-

## standards of practice

sault. (C.R.S. 1973, 13-22-106 (1979 Supp.)) If the minor's lawful custodian objects to treatment, then the physician must proceed according to provisions of the state child abuse law.

A minor fifteen years of age or older, whether with or without the consent of a parent or guardian, may consent to receive mental health services. C.R.S. 1973, 27-10-103 (1979 Supp.) The professional person rendering such services has the option of advising the parents of what is transpiring, even without the minor's consent.

Finally, birth control supplies and information may be furnished by licensed physicians not only to minors who are pregnant, or parents, or married, but also to those who request and are in need of the supplies and information. C.R.S. 1973, 13-22-105. Parental consent is still desirable if it is politic to obtain such because of the malpractice implications from prescribing for young people whom the courts might deem incapable of making a knowing consent. Colorado abortion statutes say that a woman under age eighteen should be aborted at her request *and* that of a parent or guardian. If the minor woman is married and living with her husband, she and her husband should make the request.

**Brian Stutheit**  
Director, Division of  
Professional and Patient Relations



Original art by Shelley Freshman

When you give the Mile High United Way, you help 76 vital community organizations make life more enjoyable for a lot of people, young and old and in between.



Mile High United Way  
Thanks to you, it works for all of us.



# The Arvada Medical Center

Located in the heart of Arvada at 8859 Ralston Road has a retail space and two medical suites now available for lease.

## Retail Space

Located in the front of the building on ground level and adjacent to building entrance. Large display windows easily visible from Ralston Road. Private restroom. Ideal for small pharmacy, hearing aid center or other medically related sales or service. Will refurbish to your requirements. Rent is \$405/month.

## Medical Suites

1,095 square foot suite consisting of a business and reception area. Consultation office, three examination rooms, large x-ray room with leaded walls and leaded doors with passthrough to dark room and lab, file room, storage closets and private restroom. Suite is in excellent condition but we will wallpaper or panel to suit your taste. Rent is \$776/month.

606 square foot suite consisting of a business and reception area. Consultation office, two examination rooms, small lab and a private restroom. Rent is \$430/month.

# The Arvada Medical Center

has excellent visibility, good identity and an excellent reputation. The Arvada Medical Center is on the RTD busline, has good off-street parking and a wheelchair ramp to provide easy access when needed. Common area waiting lounges are tastefully decorated with hanging plants, rich wood paneling, paintings, metal sculptures, skylights, fine carpeting and custom-designed furniture. For an appointment to see these suites, call MR. BOB LEINO (owner) at FULLER AND COMPANY — 292-3700.

# at press time ...

## **NEW PRESIDENT OF CMS CHALLENGES MEMBERS WITH PROGRAMS FOR NEW DECADE**

**K. Mason Howard, M.D.**, of Arapahoe Medical Society, was sworn in as the President of the Colorado Medical Society, succeeding Ray G. Witham, of Craig, Colorado. Dr. Howard challenged the members of the CMS to get in step with the '80s by helping to inform the patient-public, by making them better health risks, by participating more in the programs outlined by the members of the President's Planning Session, the Board of Directors and the House of Delegates. Dr. Howard applauded Dr. Witham as he left office, saying that much had happened to the general health community and, specifically, to the Colorado Medical Society during Dr. Witham's term of leadership. Dr. Howard pointed out it was a year of great reorganization of the Society; it was also a year of some major steps for the physician-members who were constantly grappling with negotiated matters, with proposed legislation which would impact health care, and of many internal programs that have been implemented and carried out.

Dr. Howard challenged the members to be ready for the changes that are to face the medical profession in this decade by stepping out ahead of those changes, following a carefully planned and selective program of activities which was agreed upon by the President's Planning Session and then approved by the Board of Directors and members of the House of Delegates. These programs, Dr. Howard pointed out, have been planned on the basis of the needs of the physician to maintain his credibility in the public sector while, at the same time, serving the best interests of public health. Dr. Howard pointed out that, for the first time in the history of the Colorado Medical Society the programs have been tied directly to a budget for the operating year which necessitated an overall budget reduction of some 10% in current programs, an increase in dues (the first increase in three years) to carry out the approved programs and to operate with a balanced budget. Planners have, for some months, been struggling with rapidly rising inflation, budgeting for programs that can carry over from one year to the next, while trying to preserve the fiscal solidarity of CMS. This, Dr. Howard points out, can be done with the new program/budget which was approved by the officers and delegates.

Dr. Howard stressed the need for all Colorado physicians to accurately bill all of their Medicaid charges, to reflect fully the services rendered and charges customarily made to the public.



## **NEW PROGRAMS BRING NEW OBJECTIVES AND A "PROACTIVE" STANCE TO CMS**

President Howard outlined the ten areas of concentration in which CMS will work during the coming year. They are:

### **COMMUNICATIONS**

CMS Officers, Board of Directors and Leadership should:

- (1) Encourage, support and implement enhanced relationships with component societies and physicians.
- (2) Have direct relationship with specialty societies including some financial support of the CMS Specialty Society Office.
- (3) Assist in publishing specialty society newsletters as a means of communication to specialty societies, including pertinent articles related to CMS issues.
- (4) Establish a program of regular meetings between CMS and specialty societies.

Strongly support continuance of *COLORADO MEDICINE* as a specific member communication tool.

Involvement and communication with other medical groups such as black physicians, women physicians, medical students, etc.

### **MALPRACTICE**

Our current professional liability insurance program is recognized as the No. 1 benefit to CMS membership. In order to continue this very important benefit we are directing and overseeing The Hartford program, including the risk management program, for the membership. We are doing a professional liability feasibility study, including an evaluation of other options, e.g., a CMS captive.

### **PHILOSOPHY OF COST EFFICIENCY**

Since the CMS has always had the responsibility of quality medical care, we, therefore, contend that the best quality of medical care is the most cost efficient. The CMS should conduct a communications program to educate its members on methods of cost efficiency and will continue to work with all health planning agencies to attain these goals.

### **COMMUNITY AND PUBLIC RELATIONS**

Develop programs with primary emphasis to assist local/component societies with public information activities.

Increase dialogue with other health groups.

Improve member image of CMS.

### **RESTRUCTURE AND FORMULATE LEGISLATIVE PROGRAM**

Restructure the method by which legislative policy of CMS is formulated and implemented so that there is optimal input from Councils, components and specialty societies and a "proactive" instead of "reactive" position reached whenever possible.

### **MARKETING FOR MEMBERS**

Develop a membership retention and recruitment program with the specific intent of promoting the benefits of CMS membership with major emphasis on the survival of fee-for-service medical practice.

### **PATIENT SELF-RESPONSIBILITY**

Provide physicians and the public (more specifically students grades 1-12), information on health issues emphasizing patient self-responsibility for health care such as seat belt and motorcycle safety, sports injury, obesity, smoking, environmental hazards, etc.

### **REVITALIZE PRIVATE HEALTH INSURANCE COMMITTEE**

To continue the function of the Private Health Insurance Committee of CMS to carry out its "original" purpose, and to provide accurate reliable information to the public and CMS members regarding health insurance policy coverage and/or otherwise to provide the health insurance industry with a mechanism to resolve specific issues regarding the delivery of medical care. To carry out the above, CMS must protect the Committee from anti-trust or other legal liabilities.

### **BUILDING**

Resolve CMS space needs through a two year building program. CMS will be less efficient and will have to curtail present services if this is not addressed immediately. Therefore, this is a matter of prime importance for the Society and the Board to consider.

### **PROGRAM OF PROFESSIONAL EDUCATION AND SCIENTIFIC ISSUES**

To develop, recommend and implement programs and policies concerning professional education and scientific issues. This recommendation continues the scientific programs and scientific issues of CMS at least at its present level of operation.

The Colorado Medical Society is participating in the American Medical Association project to improve health care in jails. AMA's concern in this area dates back to 1972 at which time they conducted a nationwide survey of health care in jails.

Survey responses revealed that the only inhouse medical services available in two thirds of jails was first aid. Approximately 16% of jails lacked even first aid services. Most jails failed to screen arriving inmates for communicable diseases or even serious health problems. Medical services were frequently provided inmates only on an emergency basis.

Law enforcement involved

A grant from the Law Enforcement Assistance Administration (LEAA) enabled the AMA to develop jail health care standards, models for health care delivery, and provide technical assistance to county jails in 22 states. Colorado's entry into the project evolved through the interest of the Colorado Medical Society's Committee on Medical Care in Correctional Institutions, chaired by Dr. John Buglewicz, M. D. As both jail physician and Fremont County Commissioner he is working with the project coordinator to overcome two obstacles: lack of interest among the medical community and lack of priority in the county budget.

Project services include assessment of selected site jails in Colorado

Project services will include assessment of compliance and non-compliance with AMA jail health standards. Appropriate technical assistance will be provided to jails interested in upgrading health services to inmates.

A preliminary survey revealed that few jails meet AMA standards related to adequate health care policies and procedures and recommended levels of health education training for jails.

The Colorado Medical Society will sponsor workshops corresponding to these topics. A "developing policies and procedures" workshop is scheduled for November 19, 1980. A 15-hour seminar providing health education training to jailers is planned for December 9th and 10th.

#### PHYSICIAN'S RUN SET FOR LATE OCTOBER. SIGN UPS DUE NOW!

Colorado doctors are getting in shape (by this time they had better be in shape) for the SECOND ANNUAL COLORADO PHYSICIAN'S RUN. The 6.2 mile race, to be held October 26th at 9:00 a.m., in Cheeseman Park, will challenge the Colorado physicians and family members who will be competing within various sex and age categories.

Registration has been recommended prior to October 24th, at Dr. Lee Anneberg's office, 1901 East 20th Avenue, in Denver. The cost (which includes a race packet, T-shirt and expert medical advice) is \$5.00. Limited registration will be available prior to race time, at the park.

#### HARTFORD RETURNS \$1.05 MILLION TO CMS MEMBER PHYSICIANS

THE HARTFORD INSURANCE GROUP IS REFUNDING A TOTAL OF \$1,050.205 TO MEMBERS WHO IT INSURES OF THE COLORADO MEDICAL SOCIETY.

THE REFUND, BASED ON A CONTRACTUAL AGREEMENT BETWEEN THE SOCIETY AND THE HARTFORD, STEMS FROM THE SOCIETY'S PROGRAMS TO HELP ITS MEMBERS PREVENT MALPRACTICE INCIDENTS. THE LATEST REFUND BRINGS TO \$2.2 MILLION THE TOTAL AMOUNT THE HARTFORD HAS RETURNED TO THE SOCIETY SINCE 1976.

FULL DETAILS IN NOVEMBER "COLORADO MEDICINE"



# What Have Epidemiologic Studies Told Us About Radiation Health Effects?

R. W. Bistline, PhD, Golden, Colorado

This is the sixth in a seven-article series reviewing the history and present knowledge of health effects from radiation exposure. In this article we shall take an overall look at the many human epidemiologic and populational studies that have been performed with regard to radiation. There have been many more studies in this area than most people realize. The associated methodology and analytical problems have been extremely complex. Epidemiologic studies can be very difficult to perform properly, especially when the effect one is trying to evaluate statistically is very small with respect to the natural incidence or is subject to influence by numerous other variable parameters.

Since the early 1900's there has been interest and concern over the effects of radiation on people. The numbers of people exposed to significant quantities of radiation were few and usually limited to laboratory researchers or workers and the medical professions and patients. In most of these cases the dosimetry to determine the levels of exposure or quantities received was extremely poor or even nonexistent. Several of the more noteworthy population studies of radiation health effects include the radium dial painter population studies, the radium therapy population, and radium chemists.<sup>1</sup> As early as 1926, mouth-tipping of radium paint brushes was ordered discontinued in the U.S. following identification of several cases of so-called "radium jaw" in 1924 by Theodor Blum, a New York dentist. In the U.S. about 50 dial painting studios employed at least 2,000 people at risk during the period high ingestion took place.

The numbers of radium treatments administered to patients for various medical conditions was large. The internal use of radium solutions was approved in the AMA's New and Non-Official Remedies from 1914 to about 1932 and it is known that more than 65 physicians and clinics were administering solutions to patients. In one laboratory alone during a five year period around 1920, more than 14,000 intravenous injections of radium (usually 10 Ci each) were made and more than 22,000 oral doses administered. The numbers of radium chemists employed in about 23 refineries and radium laboratories is estimated to have been between 500 and several thousand.

The results of the work of Evans<sup>1,2</sup>, Hempelman<sup>3</sup>, and Rowland<sup>4</sup> indicate no radiation injury (spontaneous fractures or skeletal tumors) was detectable in persons with less than about 0.5  $\mu$  Ci of radium residual body burden. Evans published a good summarizing paper on "Radium in Man" in the *Health Physics Journal* (1974).<sup>1</sup> For those interested in reviewing further the results of epidemiologic studies on mortality and cancer in radiologists and other physician specialists, in 1978 Matanoski published a paper in the *American Journal of Epidemiology*<sup>5</sup> and Court-Brown and Doll in 1958 published results on British Radiologists in the *British Medical Journal*.<sup>6</sup>

Following World War II and the large populations of people involved in radiation exposures in the atom bomb survivors of Hiroshima and Nagasaki, there have been more and more epidemiologic studies of various exposed populations ranging from high level exposures<sup>7</sup>, such as the atom bomb survivors, to populations living in natural background levels of radiation.<sup>8</sup> As mentioned in previous articles in this series, no statistical increase in genetic effects has been observed in human populations as a result of exposure to radiation.

Beebe<sup>7</sup> has published a summarizing paper on the mortality and radiation dose of the A-Bomb survivors from 1950-1974. There is still no evidence that diseases other than cancer are involved in the late mortality effects. The study of 20,230 deaths among 82,000 A-Bomb survivors from 1950 through 1974 show 762 cancer deaths and 14,405 from natural causes other than cancer. In addition to leukemia and cancer of thyroid, breast, and lung, which had been reported earlier, cancer of the esophagus, stomach, and urinary organs, and the lymphomas, are now included among the forms of cancer caused by the ionizing radiation from the 1945 atomic explosions. Evidence of a general carcinogenic effect is increasing, but no indication of bone tumors has been observed in this population. Evidence of radiation carcinogenesis did appear much stronger for Hiroshima than for Nagasaki victims. Leukemogenic effect was seen to be greatly reduced in the last five years of the study so that the average absolute risk for other malignant neoplasms now exceeds that for leukemia. The minimal latent period for most of the car-

cinogenic effects was under 15 years and depended on the individual's age and site of cancer. The numbers of excess deaths that are observed are very small but statistically significant, as an example in the case of malignant lymphoma 18 cases were expected and 23 were observed in the population of 44,509 persons studied.

The Tri-State Leukemia Study<sup>9,10</sup> confirmed the leukemia risk from prenatal X-ray exposure by suggesting a possible risk associated with pre-conception irradiation. The study also suggested that diagnostic irradiation may play a small role in adult male leukemia, and emphasized the possible existence of high risk groups who may be especially sensitive to radiation. Other epidemiologic studies of groups treated with radiation for specific medical reasons and later showing some small increased incidence of cancers include ankylosing spondylitis patients<sup>11</sup>, (with leukemia, bone tumors, and multiple myeloma), thorotrast patients<sup>12-14</sup>, (with leukemia and liver cancer), tinea capitis radiation treatment (with thyroid tumors, brain, skin, and salivary gland cancers), women having repeated chest fluoroscopic examination during treatments of tuberculosis<sup>17,18</sup>, (with breast cancer), and several other such studies.

Another type of population exposure to radiation involves those people exposed to radiation either from nuclear facilities or nuclear weapons as a result of their employment or as an involved population. Examples of epidemiologic studies of these populations include: (1) the Mancuso study of the Hanford Workers<sup>19,20</sup>, (2) Archer and Lundin studies of Uranium Miners and Millworkers<sup>21,22</sup>, (3) Lyon, *et al.* Utah Weapons Test Fallout Study<sup>23</sup>, (4) Voelz, *et al.* study of LASL Plutonium Workers<sup>24</sup>, (5) Najarian's Shipyard Worker Study<sup>25</sup>, and (6) Johnson's study of Populations in the Denver-Rocky Flats Area.<sup>26</sup> With the exception of the Voelz study, all of these other studies purport to show various types of cancers at levels significantly above those of the cohort or control populations used for comparison.

At the beginning of this article it was noted that epidemiologic studies can be extremely difficult to perform properly, especially when the effect one is trying to evaluate statistically is small with respect to the natural incidence and confounded by numerous other influencing variable parameters. This problem is particularly true in the case of many of the epidemiologic studies investigating the health effects of low level radiation. The earlier articles in this series have pointed out that cancer is the predominant health effect seen as a result of radiation either from external or internal exposure. Cancer is a major natural cause of death in the U.S. popula-

tion approaching 20 per cent of the annual deaths. Thus, the incidence of cancer is normally high and the normal frequency of cancer varies as much as 100 per cent among areas of the United States<sup>27</sup> and metropolitan areas have statistically higher incidences of many types of cancers when compared to incidences in outlying areas with lower population densities.<sup>28</sup> In fact, for many types of cancers, the metropolitan counties with a central city have two to three times the incidences of the counties without a central city.<sup>28</sup> Of the sample epidemiologic population studies noted in the previous paragraph, the Johnson study, the Mancuso study, the Najarian study, and the Lyon study have all been discredited by peer epidemiologists for their poor methodology, improper statistical procedures, improper assumptions, and/or improper use of data.

The Johnson study of populations in the Denver-Rocky Flats area has had review by the EPA<sup>29</sup>, the NRC<sup>30</sup>, the Colorado State Health Department<sup>31</sup>, and the Lovelace Foundation<sup>28</sup>. This study has been cited as having serious problems in all of the above mentioned problem areas. The Mancuso study likewise has been discredited. The Mancuso study found no increase in leukemia but rather an increase in a couple of other types of cancer among the Hanford occupationally exposed workers. Most of the criticism is over the statistical methodology used by Mancuso<sup>32-35</sup>. This study had reported higher longevity in the worker population over their matched controls and siblings in their previous annual reports where conventional statistical evaluations of the data were used.

The Najarian study of some former employees of the Portsmouth Naval Shipyard and the Lyon study of Utah childhood leukemias associated with fallout from nuclear testing have likewise been questioned by peer epidemiologists<sup>27</sup> and extensive re-evaluations of these populations by internationally recognized peers is now underway. Here also is an example in point where the Najarian study looked at a population and tried to correlate three cases of leukemia as a significant increased number over the number expected. A very important fact from the Voelz study of plutonium workers at LASL<sup>24</sup> is that in this 30-year mortality and incidence follow-up of a population of 224 workers who had exposures of greater than 10 Ci of plutonium the data indicate no excess of lung cancer and the total cancer and cardiovascular mortality rates were lower than expected based on age and year-specific rates. One should keep in mind that this population had 30 year exposures of orders of magnitude greater than any general populations have experienced around any nuclear facility in the



U.S. Some of the above examples only serve to point out the problems one confronts in trying to prove a few cancers are due to low level radiation when 20 per cent of the deaths in our population are a normal result of cancer. The populations and environments are continually changing with variables such as age, residence time, pollution, socio-economic, population density, and many other parameters undergoing continuous dynamic change.

In summary, it can be said that some well done epidemiologic studies have shown some

correlations and trends between radiation exposures and a small increased incidence of cancer when exposures were at relatively high levels. However, at low exposure levels "The limitations of the epidemiologic approach to the measurement of human health effects of ionizing radiation discourage any expectations that epidemiologic studies alone will provide the answers. At the very low dose levels that are of the greatest practical concern to us . . . the underlying risks may be beyond the resolving power of present epidemiologic methods to measure directly"<sup>36</sup>.

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# Education Consortium Planning New CME Service

Colorado continuing medical educators will soon have the use of a new educational service. Persons planning CME programs will receive a list of clinical topics suggested by most of the major specialties and sub-specialties of medicine. The service will also provide the name of a "contact person" in each specialty who will receive requests for speakers on listed topics or other topics identified locally.

Topic listings and names of contact persons will be published under the title *Clinical Topics for Continuing Medical Education Programs: Suggestions From Medical Specialty Societies*. The publication will be distributed shortly to continuing medical educators throughout the State of Colorado and to others interested in continuing medical education. There will be no charge for the service.

*Clinical Topics* is provided by the Colorado Consortium for Continuing Medical Education, an organization which helps the University of Colorado School of Medicine, the Colorado Medical Society and the Colorado Foundation for Medical Care to cooperate in providing supporting services for continuing medical education in Colorado. Dr. Robert Sawyer, Chairman of the Board of the Consortium, said that the need for the clinical topics service was determined from conversations with physician medical educators, especially those in rural hospitals. Many reported that they occasionally had difficulty choosing the most important topics to cover when planning their CME programs, and also in identifying speakers on those topics.

This will be the first edition of *Clinical Topics*.

In about a year, a second edition will be published including updated topic listings from medical specialty societies. Contributors to the first edition include representatives of 16 specialty and sub-specialty societies in the State of Colorado. The societies have listed topics they believe will be of special interest to general physicians. Each listing includes a brief description of the topic and its significance for the general physician.

Contact persons listed by each of the specialty societies have indicated their willingness to receive calls from continuing medical educators and to assist in identifying speakers to respond to requests from the field. Although there is no charge for the new publication or for conversations with contact persons, once a speaker has been identified, financial arrangements are between the speaker and the requesting hospital or physician.

Dr. Sawyer added that the listing of contact persons from each medical specialty should make it easier for physician educators throughout the state to identify persons who are willing to speak on clinical topics or who can assist rural physicians with specific clinical problems encountered in their practice.

Although requests for speakers on specific topics should be addressed to the contact person in the appropriate specialty, questions concerning the overall operation of this service should be addressed to Kevin P. Bunnell, Ed.D., Executive Director, Colorado Consortium for Continuing Medical Education, 861-1221 x 262, (WATS # 1-800-332-4150 x 262).

## Colorado Consortium for CME Identifies Program Goals

A new program agenda for the Colorado Consortium for Continuing Medical Education came out of a recent meeting of the Board of Managers. Priorities for the coming year are as follows:

- Initiate one project of research on the processes of continuing medical education (quality, impact, knowledge/age variables, needs assessment);
- Plan and sponsor a course on the use of computers and/or telecommunication technology by practicing physicians;
- Plan and sponsor one major event related to liberal education for physicians;
- Plan and sponsor one series of educational programs based on the findings and recommendations of the Medical Care Evaluation Committee of the Colorado Foundation for

Medical Care;

- Plan and sponsor a national conference on innovative ideas in continuing medical education.

The Consortium was established two years ago by the Colorado Medical Society, the Colorado Foundation for Medical Care, and the University of Colorado School of Medicine, to support Colorado organizations that provide continuing medical education. All of the listed projects will require joint effort by organizations in the state committed to supporting CME. Readers having a special interest in any of the above topics are urged to get in touch with Kevin Bunnell, Executive Director, Colorado Consortium for Continuing Medical Education, at 861-1221 x 262 or 1-800-332-4150 x 262.



## MEDLINE in La Junta

As an important element in the ongoing process of Continuing Medical Education, the Denver Medical Society Library regularly extends itself in the cause of providing assistance to doctors in their search for information.

In amplification of this objective, Dr. Kevin Bunnell, director of the Continuing Education Division, traveled on July 13 to La Junta for a presentation on Computers and Medicine. He was joined for the session by Martha Burroughs, reference librarian of the Denver Medical Society Library, who was scheduled for a MEDLINE demonstration.

Dr. Dean Girard, Chief of Staff of the La Junta Medical Center, had arranged the program for doctors on its staff, as well as other doctors from Las Animas. The appreciation of these doctors and the staff for this visit was very clearly indicated by their receptive attitudes.

Prior to going to La Junta, Martha had arranged for a toll free line and number, at the same time that she was given a special demonstration code by the National Library of Medicine.

Dr. Girard had prepared the doctors to develop ideas on what they wanted out of the demonstration. Most requests were in the fields of forensic, surgical, and gynecologic medicine.

Enthusiastic doctors worked on those doctors of more reserved appreciation, and once the print-out started rolling, the main hurdle was surmounted. MEDLINE was very strongly shown to be a significant, functioning means of deriving information.

### How to use MEDLINE

For computerized literature retrieval, use the free WATS in-line, 1-800-332-4150. Call Martha Burroughs, Denver Medical Society reference librarian, and tell her your needs. Through computer, she will request the required information from the National Library of Medicine. Immediate transmission of materials published since 1978 will take place, while literature published since 1966 can be obtained in less than a week.

## Colorado Medical Society

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## The Regulator: Medical Appropriateness Reviews Begin

The Colorado Department of Health, which is the designated State Health Planning and Development Agency, is now and will be considering the practice patterns of physicians in the following areas:

	HSA Review	SHPDA Review End date
<b>Cycle 1</b> End-Stage Renal Disease Services	6-11-80 to 12-7-80	12-7-80
<b>Cycle 2</b> Cardiac Catheterization and Open Heart Surgery Radiation Therapy Computerized Tomography	12-11-80 to 6-10-81	6-10-82
<b>Cycle 3</b> Long Term Care Services Home Health Care Services	6-11-81 to 12-10-81	12-10-82
<b>Cycle 4</b> Emergency Medical Services Critical Care Services	12-11-81 to 6-10-82	6-10-83
<b>Cycle 5</b> General Medical/Surgical Services Obstetrics/Newborn Services Pediatric Services	6-11-82 to 12-11-82	12-11-83

It is imperative that specialty society groups begin to formulate their own "appropriateness" review documents for these regulatory entities to react to. If there are any questions, please call Robert FitzGerald at CMS.

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## DATES TO REMEMBER:

October 3—Last Day to Register for the general election

October 20—Earliest date to receive an absentee ballot

October 30—Last day to submit an absentee ballot

November 4—GENERAL ELECTION

Six ballot issues will face all Colorado voters when they go to the polls next month. Your Government Affairs staff has used the analysis prepared in the Legislative Council offices in the Capitol to explain the pros and cons of each issue. (AMENDMENT NO. 4 SHOULD BE OF SPECIAL INTEREST). No effort has been made to comment on further ballot issues, such as taxation for a light rail system and the establishment of a regional service authority. These will be voted on in only a few counties and thus are not of statewide interest. Information on such local issues is available, however, in the CMS office.

The first four measures are proposed amendments to the constitution. Amendments 1 and 2 were referred by the General Assembly, and amendments 3 and 4 are initiated measures. If approved by the voters, these four constitutional amendments could only be revised by a vote of the electors at a subsequent general election.

The statutory proposals, amendments 5 and 6, are both initiated measures. If approved by the voters, these items may be changed by the General Assembly. Initiated measures may be placed on the ballot by petition if not less than 8% of the qualified electors have signed the petition.

### AMENDMENT NO. 1—CONSTITUTIONAL AMENDMENT PROPOSED BY THE GENERAL ASSEMBLY

#### Ballot Title:

An amendment to article V and XIX of the constitution of the state of Colorado, concerning the initiative and referendum process, and providing that an elector must be registered in order to sign a petition for an initiated or referred measure and that the proposed initiated measures shall be submitted to the legislative research and drafting offices of the general assembly for review and comment at a meeting open to the public before a ballot title is fixed.

#### Popular arguments for:

1. The present procedure in which any *qualified elector* may be eligible to sign an initiative petition makes any challenge of the signatures impractical because there is no official record of qualified electors. The likelihood of fraud in the petition process would be greatly reduced by

## November Ballot Issues: Pros and Cons

requiring the signatures of *registered electors*.

2. The amendment would place greater responsibility on those persons circulating petitions to determine the eligibility of the signers.

3. The amendment would reduce the number of signatures needed to propose an amendment by initiative from 8% to 5% of the total votes cast for the Secretary of State at the previous election. It would also extend the date for collection of signatures by one month.

4. An open public meeting would help assure that all relevant questions and issues surrounding the proposals are raised at the proper time—before the circulation of the petition for signatures.

#### Popular arguments against:

1. The proposed amendment would mean that nearly 500,000 Coloradoans, 18 years of age and older, would not be eligible to sign an initiative or referendum petition simply because they are not eligible to vote.

2. Rather than ensure the integrity of petitions by requiring that signers be registered electors, the amendment would create uncertainty for both potential signers and circulators of petitions regarding whether an individual was a registered elector.

3. The *original* draft of an initiative may be changed prior to the time the measure is circulated for signatures. Thus the information made available to the public at the proposed hearing may not reflect the actual language of the final petition.

4. Colorado's initiative process has not resulted in an unreasonable number of statewide measures appearing on the ballot.

### AMENDMENT NO. 2—CONSTITUTIONAL AMENDMENT PROPOSED BY THE GENERAL ASSEMBLY

#### Ballot Title:

An amendment of section 2 of article XVIII of the constitution of the state of Colorado, authorizing the establishment of a state-supervised lottery with the net proceeds, unless otherwise authorized by statute, allocated to the conservation trust fund of the state for distribution to municipalities and counties for park, recreation, and open space purposes.

Based on an *estimated* Colorado population of 2.7 million, the following amounts of money *might* be raised from various per capita net revenues:

Per Capita Net Revenue	Estimated Lottery Revenue Based on Population of 2.7 Million
\$ 3.00	\$ 8.1 million
\$ 5.00	\$13.5 million
\$10.00	\$27.0 million

**Popular arguments for:**

1. A state sweepstakes was approved by Colorado voters at the general election in November 1976. Implementation of the Colorado sweepstakes, one form of a lottery, was delayed on the basis of a legal technicality. This proposal simply resolves the legal issue by granting the state constitutional authority to the General Assembly to establish a state-supervised lottery.

2. As early as 1974, the General Assembly recognized the need to establish a conservation trust fund to assist local communities in the development of park and recreation facilities. The program, however, has always lacked a viable revenue base.

3. A state lottery provides an opportunity to raise revenues without the imposition of a direct tax. The purchase of a lottery ticket is voluntary. Any subsequent legislation could be revised by the state legislature to correct any abuses or to allocate lottery revenues for public purposes that were deemed to be a higher priority or a more critical need.

4. 75 percent of the persons living in states with state-operated lotteries favor legalization of lotteries. The percentage of persons supporting legalization of lotteries in such states is much higher than the number of persons who actually purchased lottery tickets.

**Popular arguments against:**

1. The 1976 sweepstakes proposal was a statutory measure that would have authorized a state agency to operate a sweepstakes. The current proposal is a constitutional amendment that would permit the General Assembly to authorize any type of lottery. It would open the door for those persons associated with the gambling industry to exert pressure on elected officials to expand the gambling activities.

2. Not only is this form of gambling a poor way to raise money for public projects, it is also inefficient and expensive. All the lottery states have found that constant revision of the lottery format is needed to hold the public interest. This means that a portion of gross revenue must be used for promotional and administrative expenses.

3. Gambling weakens the moral fiber of the individual and lowers the ethical standards of the community. Government should not be in the business of publicizing and promoting an activity that rewards according to "chance" rather than on constructive, creative human activity.

4. The Colorado Constitution currently authorizes the conduct of bingo games and raffles by nonprofit organizations. The citizens of Colorado have only a certain finite amount of discretionary income available for participation in charitable raffles and lotteries, and the authorization of any new state lottery would provide competition for these nonprofit programs.

5. Lotteries in the various states with legal games are

placing increased reliance on the so-called "instant games" while the purchaser can assess the results immediately. The effect has been a growth in the repetitive purchase of lottery tickets. This proposal could mean the development of instant games in Colorado, or a publicly policy in Colorado that fosters a very regressive form of gambling which could have its greatest impact on low income groups.

**AMENDMENT NO. 1—CONSTITUTIONAL AMENDMENT INITIATED BY PETITION**

**Ballot Title:**

Shall article II of the constitution of the state of Colorado be amended to provide that an unincorporated area may be annexed to a municipality only if the annexation has been approved by a majority vote of the landowners and the registered electors in such area who vote on the question, or if the annexing municipality has received a petition for annexation signed by persons comprising more than fifty percent of the landowners in such area and owning more than fifty percent of such area, or if such area is entirely surrounded by or is solely owned by the annexing municipality; and providing that this section does not apply to the city and county of Denver to the extent that annexations thereto are governed by other provisions of the state constitution?

**Popular arguments for:**

1. The present system of unilateral annexation by the governing body of a municipality—in which the residents of certain areas proposed to be annexed have no representation in the decision of government—is contrary to our democratic principles of representative government.

2. Qualified electors who are residents of the area involved in the annexation but who are *not* landowners would be able to vote. Renters have a financial stake in an annexation.

3. The residents and landowners of an area are in the best position to determine whether an annexation would be desirable or whether more government is needed.

4. The proposal would help ensure that annexations must be based on consent, thus tending to discourage uneconomical finger annexations which raise the cost of government for municipal residents. The present energy crisis suggests that municipalities should do more to concentrate growth within existing boundaries rather than encourage uneconomical finger annexations.

5. There are indications that for many larger governmental units the per capita costs of governmental services tend to be higher and government less responsive to neighborhood needs than smaller entities.

**Popular arguments against:**

1. The rights of landowners and residents in fringe areas adjacent to municipalities should be equal to, but not greater than, those rights provided for municipal residents. Municipal residents should have equal constitutional voting and petition rights in matters involving the extension of municipal services to unincorporated areas.

2. The amendment addresses only one side of complex economic and governmental issues relating to the provi-



sion of governmental services to rapidly expanding urbanized areas. Restrictive annexation laws (such as proposed by this amendment) tend to encourage the formation of special districts, involvement of county government in the provision of urban services, and the incorporation of new cities and towns adjacent to existing municipalities. Fragmentation of local governments prevents compatible development of an urbanized area and ultimately means higher cost of government for everyone.

3. Fringe area residents have a fundamental responsibility to the social and economic community of which they are a part and should not be given carte blanche authority to remain a tax free peninsula without responsibility to the total community.

4. Most annexations in Colorado are voluntary, involving petition by the landowners. The amendment may make it more difficult to implement voluntary annexations because a majority of landowners, rather than those owning a majority of the land, would have to petition for annexation. The ultimate effect of the amendment may be to discourage the extension of municipal services to newly developing areas because the amendment would make the overall economic growth and expansion of a municipality much more difficult. Thus the amendment could have a negative impact on land values on the fringes of some municipalities and reduce the economic viability of both the incorporated and unincorporated areas.

5. For enclaves and areas with two-thirds boundary contiguity with a municipality, the present annexation law contains a carefully constructed compromise between the needs of landowners of the unincorporated area and the municipality. The amendment destroys this tradeoff by removing the unilateral annexation authority to the city but does not give the municipality the right to refuse to accept an annexation petition by the landowners of such an unincorporated area.

6. The issue of annexation is extremely complex involving a variety of urban issues and affecting residential and commercial construction and related business activity; patterns of employment; transportation facilities and services; the character of neighborhoods; zoning; availability of water, sewer, and other governmental services; the formation and expansion of special districts and new municipal governments; the expansion of existing municipal governments. The proposed constitutional amendment, however, addresses only one aspect of the annexation issue and would restrict the capacity of the General Assembly to balance these issues with changing conditions. The amendment is silent as to the definition of "landowner." Since the meaning of "landowner" is unclear, the initiative and voting rights of landowners may not be restricted only to Colorado and United States residents or persons 18 years of age and older. Furthermore, a question exists as to whether owners of mineral rights could exercise franchise in annexation matters.

**AMENDMENT NO. 4—CONSTITUTIONAL  
AMENDMENT INITIATED BY PETITION**

**Ballot Title:**

Shall article XVIII of the constitution of the state of Colorado be amended to provide that in order that all persons shall have the right to sell or transfer their real estate or any interest therein subject to existing financing, no person or lending institution with a security interest in the real estate shall accelerate or mature the indebtedness secured by such real estate or alter the terms and conditions of the indebtedness or security interest because of such sale or transfer, so long as the original debtor remains directly responsible for the indebtedness and the security for the indebtedness is not substantially impaired by the sale or transfer?

**Popular arguments for:**

1. The current high interest rates often make it extremely difficult for potential buyers of property to qualify for new real estate loans. Under present economic circumstances, if a property owner cannot offer an opportunity for the buyer to base his financing on an existing mortgage, the property owner may not be able to sell his property. The amendment is designed to ensure that a lender could not disrupt the sale of property in those instances in which the original borrower remains responsible for the outstanding indebtedness and the security of the lender is not impaired.

2. Alternatives to existing institutional financing are needed to stimulate real estate finance. The amendment would encourage competition in capital formation important for a high growth, capital short area such as Colorado.

3. The amendment specifically addresses the continuing responsibility of the property owner for any acceleration of a real estate loan when the security of the lender is impaired. For a lender to accelerate a loan when his security interest remains unimpaired is unreasonable, particularly when the lender invokes an early payment penalty. Why should the homeowner who is fortunate enough to remain in his property benefit from a fixed interest rate while those property owners who are forced to dispose of their property lose part or all of their equity because of an acceleration clause?

4. Both the Veterans Administration and the Federal Housing Administration prohibit the acceleration of VA and FHA loans simply because of the sale or transfer of a property. The Federal National Mortgage Association, a governmentally sponsored but privately owned corporation, permits the inclusion of a due-on-sale clause in its uniform mortgage instrument. The provisions of this amendment are in substantial conformity with the aforementioned policies.

**Popular arguments against:**

1. It simply is not sound business practice for a mortgage lender to allow a subsequent buyer—with whom the lender has no contractual or other relationship—to take possession of the property without qualification of the subsequent buyer. The requirement that the original borrower would remain liable for repaying the loan does not neces-

*(Continued on page 362)*

## ONCE UPON A TIME STORIES

Late September 1982

Lobby—St. Mary's Hospital

**Dr. Member:** "Hi, Pass, haven't seen you for a long time—what's up?"

**Dr. Pres:** "Goodie? It is nice to see you! Love to talk but got to run down to the Fairmont Hotel for another damn Medical Society meeting."

**Dr. Member:** "Are you still playing Medical Society games?"

**Dr. Pres:** "Yep, and I love it. The Society is getting better all the time except for all these meetings—in these crazy places."

**Dr. Member:** "What are you talking about, Pass?"

**Dr. Pres:** "Goodie, do you remember a couple of years ago, the Board of Directors said we had run out of space for staff, and meetings, and it was affecting a whole bunch of things?"

**Dr. Member:** "Vaguely. Never was much interested in that stuff you know."

**Dr. Pres:** "To make a long story short, the staff and Board were excited about how they could do the new programs and projects, expand operations, add staff, in their present facilities. I remember the EVP making a presentation at a President's Planning Session, then to the Finance Committee and the Board."

**Dr. Member:** (Aside—"God this is dull") "So what?"

**Dr. Pres:** "Well, to make another long story short, there were a lot of arguments about why did we really need to build, a constant assessment of staff needs, meeting room needs, parking, where to locate, who would be in such a facility, how to finance it, who had the day-to-day authority to oversee it, physicians, staff, etc." Goodie, it was a mess!"

**Dr. Member:** "Pass, what happened?"

**Dr. Pres:** "Have you been down to the Medical Society lately?"

**Dr. Member:** "Not in two years and it was pretty chaotic then."

**Dr. Pres:** "Well, to make a longer story shorter—The staff is really on top of each other. We haven't been able to add additional staff to take on some new member service programs. We are located in three downtown locations—with executives in each. In fact, I don't know how they talk to each other or coordinate anything. There is one telephone for three people."

**Dr. Member:** "Sounds awful!"

**Dr. Pres:** "Goodie, that's not the worst of it. Sure the staff is overcrowded and inefficient and they complain a lot, but the worst—well, I hate to even think about it."

**Dr. Member:** "Come on Pass—what?"

**Dr. Pres:** "They took away my office. In the latter part of my year as President, they would use the office for staff that didn't have a desk—and I'd go in at night. Then they started a four-day week to conserve energy and maximize space, but they had two shifts and I still didn't have a place to work. Plus, it took me an hour from my office to get across town and then *no*, absolutely NO parking. It cost *me* \$15.00 to park *and WALK*."

**Dr. Member:** "Boy, I'm glad I never got involved with the Medical Society—that kind of nonsense would have been the straw that broke my back."

**Dr. Pres:** "Not only yours, but ours. To make a really long story really short, the Medical Society and the Foundation paid over \$1,789,387.07 in rent in the 7 years they have been in these quarters. Since it was all rent, *no* monies have been accrued to the Society—no equity has been built for you or me. Hey, I've GOT to run."

**Dr. Member:** Good to see you Pass—I'm really sympathetic. If I can help, let me know. By the way, what meeting are you off to now?"

**Dr. Pres:** "Down to the Fairmont Hotel for a Medical Society meeting."

**Dr. Member:** "Why there?"

**Dr. Pres:** "We haven't had a meeting at the Medical Society for a year and a half because all the meeting rooms are being used for other purposes. Of course, there's a bright side, the Medical Society has had a budget of \$220,000 for outside meetings, food, etc. Our \$50 dinners are really nice perks."

**Dr. Member:** "What's the meeting?"

**Dr. Pres:** "Oh, it's our weekly meeting of the Building Committee. See ya."

**Executive V.P. Note:** Names and places have been changed to protect the innocent and uninitiated, however, any resemblance to the current and developing situation is purely on purpose.



## Review of Grievance Committee Cases 1978-79

What produces a grievance? Circumstances may vary but the CMS Grievance Committee's review of cases completed during the year 1978-79 reveals a common thread: the need to talk and to listen.

Fifty grievances were reviewed by the Colorado Medical Society Grievance Committee during the Society year ending September 14, 1979. Sixteen cases concerned justified complaints in the view of the Committee, while 26 were closed unjustified. Eight remain unresolved because complainants either left Colorado or lost interest in pursuing the grievance during the course of Committee investigation.

Two cases were referred to the *Board of Medical Examiners*. Both concerned a physician who had met with the Committee and evinced no willingness to alter practice patterns which were fathoming multiple grievances and raising serious ethical questions.

### Unprofessional Conduct Alleged in Seven Cases

In assessing complaints which alleged unprofessional conduct, the Committee saw a true dichotomy. Of the three cases deemed justified, one subject left the state; two removed themselves from practice situations grown untenable.

In contrast, three of four unjustified complaints were not pursued by the originator when the Committee replied. The fourth was an unfounded accusation of failure to forward records.

### Communication an Element of Patient Care

Of five complaints which stemmed from either a breakdown or an element of abrasiveness in communication, two were closed as justified. The breakdown had clearly affected patient care: one patient was forced to undergo unnecessarily duplicative examinations; the second never received test results. The remaining three complaints were the product of misunderstandings which were resolved.

Eighteen complainants requested review of the *quality of care* received from member physicians. In six cases, the Committee found that care was of sound quality and that dissatisfaction had been borne of a natural desire for a different outcome of treatment. A number of unjustified complaints, seven altogether, could be traced to a failure in communication; the patient had been looked after properly but without sufficient explanation. Justification existed in four cases involving failure to make an appropriate referral, poor record-keeping, and insufficient ex-

# committee report

amination, testing, and supervision of employees. One case was not pursued by the complainant.

### Fee Problems Resolved in Discussion

Fees accounted for fewer complaints—11 altogether. The Committee drew the attention of the members named in three justified complaints to errors in billing which were corrected. Six of the complaints did not remain subjects of controversy after the Committee encouraged further discussion between the doctor and the patient. Two complaints were abandoned by the originators.

Two instances involved insurance. In the first, a justified complaint, the Committee assisted the patient to secure an itemized bill necessary for reimbursement. In the second, the insurance company, rather than the physician was found to be the source of grievance.

### Five Professional Disagreements Discussed

Efforts to resolve intra-physician and lawyer-physician complaints (five in all) resulted in cancellation of two claims and achieved some success in three. In this category, the adversaries often will not relinquish rigid prior assumptions about the other. Resolution is at best an uneasy peace, when professional disagreement has been permitted to grow to the magnitude of a grievance.

### Talk Can Keep a Complaint From Becoming a Grievance

At almost any time, many patients' complaints can be remedied if they are given the opportunity to talk about a misunderstanding with the doctor rather than an outsider.

As a general rule, the grievance staff's first question to callers is, "Have you talked with your doctor about this?" At least half of the callers have either felt reluctant to approach the doctor or have been discouraged by a "protective" office staff. There is reason to question the "protective" quality of a staff which so efficiently discourages inquiries that patients' frustration builds to lodging a complaint.

Devoting a few minutes to resolving a misunderstanding (the head of Pediatrics at Massachusetts General Hospital has a telephone hour early each morning during which patients' parents can talk with him directly) can spare one the hours the Grievance Committee is obliged to ask in studying a complaint.

sarily protect the lender, especially if the original borrower is an individual who cannot later be located or a corporation that later ceases to exist.

2. The amendment could jeopardize the flow of mortgage money into Colorado. Mortgage funds from outside of Colorado are needed to house an expanding population and for the commercial and industrial development necessary to service and support the economy.

3. The amendment would not have general applicability to all real estate transactions in which there is an existing mortgage on the property. The amendment would not apply to a real estate transaction in which the purchaser assumes the loan and the original debtor is released from liability.

A major question raised by the amendment is whether it would be applicable to existing mortgage contracts which contain a due-on-sale provision. Finally, it is doubtful whether the amendment would be applicable to federally chartered savings and loan institutions.

4. The amendment would have an adverse impact on savers, first-time home buyers, potential new home buyers, and the housing and construction industry. Lenders are able to reduce the impact of below market loans through renegotiation of interest rates at the time of sale of the property. Without this opportunity, lenders will have to balance their portfolios by a substantial increase in interest charges for loans for those persons buying new properties or requiring a second or third mortgage. Thus the economic burden imposed by the amendment would fall on younger families with fewer resources.

5. This amendment could have a significant impact on real estate finance in Colorado, but at this time no one can forecast its ultimate effects with accuracy. The sponsors could have initiated this proposal as a statute which, if later proven to be detrimental, could be modified by the General Assembly. The constitution, however, can only be changed every two years, and then only by the voters. It does not make sense to place such a complex issue in the Colorado Constitution, especially when the amendment is so likely to be the subject of litigation.

#### **AMENDMENT NO. 5—PROPOSED STATUTE INITIATED BY PETITION**

##### **Ballot Title:**

Shall any bank, beginning July 1, 1981, be permitted to establish one or more branch banking facilities separate from the principal office of the bank anywhere in the state if the banking board determines that the proposed branch will serve the public need and convenience in the community or area to be served, all administrative costs of filing and processing an application for a branch to be paid by the applicant bank?

##### **Popular arguments for:**

1. Many Coloradans do not have easily accessible banking services. Colorado banks are prohibited from offering complete services in more than one location. Despite increased population growth and changes in economic conditions, a bank, unlike other businesses, cannot open offices at shopping centers, industrial parks, and new residential areas. This limitation on branching may require consumers to spend additional time and money for travel to

obtain bank services.

2. Savings and loan associations have had authority to open branches in Colorado for many years. New federal legislation and the capacity to operate branches may give federal savings and loan associations an advantage over commercial banks in attracting depositors. The proposed amendment would help restore a competitive balance between these types of financial institutions and allow freer competition in the marketplace.

3. There are nearly 100 communities in Colorado which have only one bank and many more communities with only two banks. Small businesses and individuals in these communities depend on the local bank for financial services. There may be little incentive for a bank to improve efficiency and reduce costs for services when it is not confronted with competition in its market area.

4. The cost of chartering a new bank in many small communities or fringe areas of large communities in which development is taking place often requires more capital than may be justified based on expected demands for bank services.

A branch facility can be opened for less capital than chartering of a new bank and does not require all the operating personnel and administrative staff required of an individual home bank.

5. An individual bank does not have the opportunity to spread risk among as wide a range of economic activity as that available to a bank with a number of operating branches.

##### **Popular arguments against:**

1. The amendment could result in a higher proportion of bank deposits being concentrated in the larger metropolitan banks. Banks with the largest capital resources would be in the best position to open branches in order to increase deposits. Thus smaller financial institutions might not be able to maintain their current proportion of deposits.

Rather than increasing competition, branching in the long run may reduce the relative number of banks serving Coloradans.

2. Investment decisions under any branch banking system tend to be under the control of the home office. No longer would each full service bank facility in Colorado have its own board of directors to help determine loan policy. Branches could serve as collection points for community savings, but the loan and investment decisions would tend to be made by the home office.

Large banks cannot be expected to have the orientation and concerns of a unit bank serving a small community. Branch banking could mean less attention to individual community investment requirements and greater focus on the capitalization needs of larger industries.

3. Bank regulation by the federal government and in the majority of states has been based on a fundamental policy of keeping banking resources decentralized.

Decentralization of the financial system has been part of the economic policy for Colorado. The amendment would be counter to the carefully formulated policy of Colorado's elected officials.

4. Although branching probably would not result in an immediate change in Colorado's banking structure, the



statistical data of other statewide branching states suggests that the proposal would gradually result in greater concentration of deposits in fewer banks.

**AMENDMENT NO. 6—STATUTE—INITIATED BY PETITION**

**Ballot Title:**

Shall the Colorado Revised Statutes be amended to provide for the election of one director from each director district for a fifteen member board of directors of the Regional Transportation District?

**Popular arguments for:**

1. The governing board of the Regional Transportation District is not directly accountable to the people through an elective process.

No elected official and no elected body actually approves the budget of the district. Accountability, whether it involves the expenditure of public funds, operational efficiency, personnel management, or other measure of performance, may be achieved by making elected officials directly responsible for government programs.

2. Some citizens may be unaware that local officials are involved in making appointments to the RTD board. The appointive process is deficient in not providing citizens with a mechanism for recall of a member from the governing board of the RTD.

3. The Regional Transportation District is the fourth largest governmental unit in terms of spending in the state of Colorado with a 1980 budget in excess of \$137 million. The enormous expenditure of public funds by the district places the governing board of the RTD in a different position than most other appointed boards and commissions.

In addition to sheer size, the complexity of issues confronting the RTD involves deep philosophical differences among residents of the community.

Decision-making in the area of public transportation must be responsive to and shared by the public. Candidates for office to an elected RTD board would debate these issues. Direct election of the RTD governing board might help to achieve a public transit policy that would balance the conflicting needs of residents of the community.

4. The present appointed board of the Regional Transportation District does not provide equal representation in terms of the estimated 1980 population of the district.

The establishment of individual director districts on a population basis as proposed by the amendment would help ensure that board representation would be evenly apportioned throughout the metro area.

5. The 21-member appointed board of the Regional Transportation District may be too large to function efficiently as a governing body.

The proposed reduction in size of the Board and the requirement that each board member serve from a director district would mean that one board member would represent any given area in the RTD. Each board member would be familiar with the geography and needs of his area. Thus residents of any given area in the RTD could contact their representative on the board.

**Popular arguments against:**

1. Public transit is a key element in community land use planning and traffic control systems. Appointed boards

provide direct lines of communication between the transit districts and municipal and county officials. An independently elected board, in which members would be elected from director districts which need not coincide with existing political boundaries, might weaken existing cooperation between the RTD and other local units of government.

2. An effective public transit system is far more important to the densely populated City and County of Denver than to suburban communities. Denver also collects nearly 40 percent of the sales tax collected by the RTD. Apportionment of an elected board on the basis of population would mean that Denver's influence on the decisions of the governing board of the Regional Transportation District would be greatly reduced.

3. Under the provisions of the proposal, any qualified elector may file for candidacy to the board by filing the signatures of 100 registered electors. This could mean a very large number of candidates running in each district.

The proposal does not provide any procedure for a runoff election and does not utilize a primary election in order to reduce the number of candidates. A large number of candidates for an RTD director district seat could make it difficult for candidates to inform voters of their views.

An elective system that might force candidates to seek large campaign donations increases the vulnerability of board members and candidates to be influenced by special interest groups. It would not be in the public interest to develop an elective system in which it would be possible for a candidate to be elected to the RTD board by only a small percentage of the total votes cast in a director district.

4. The appointive process provides flexibility in the development of a board with a broad-based perspective. The present procedure permits the appointing authorities to nominate persons with a wide variety of skills in business, finance, labor, government, consumer affairs, land use and transportation planning, etc. Inherent in the power to appoint is the power to remove. Board members of the RTD have resigned when requested by appointing authorities.

The present appointive structure of the RTD board permits members to view decisions from a regional perspective. A board comprised of individuals elected from director districts would be subject to considerable pressure from the parochial interests of their respective constituencies to the detriment of an integrated and comprehensive public transit system.

5. The proposed amendment could mean that the present board of the Regional Transportation District would become a "lame duck" board at a critical time in the development of transit systems in the Denver Metropolitan Area. Voters in the RTD will be considering whether to authorize funding for the construction of a light rail system at the November general election. Under this proposal, the present board members and new members appointed in July 1, 1981 would serve until January of 1983. Thus for nearly two years, the appointed board would be in office at a time in which there could be considerable negotiation with transit planning consultants, contractors, and local governments. There could be great reluctance among such individuals and organizations to make commitments to a lame duck governing board.

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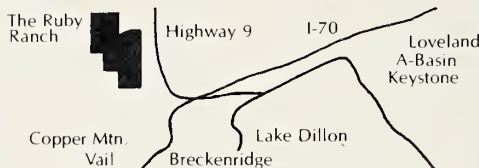
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L to R: Ray G. Witham, President of CMS, presenting check for \$14,251.84 to Dr. Steven Doubousky, Associate Dean for Student Affairs, University of Colorado School of Medicine, as Ruth Yost, Chairman of the AMA-ERF Committee of the Colorado Medical Society Auxiliary looks on.

The American Medical Association-Education and Research Foundation in 1980 returned \$14,251.84 to the Colorado Medical Society Auxiliary for distribution to education and research uses. Ruth Yost, Chairman of the Auxiliary AMA-ERF Committee says that is the amount contributed by CMS member physicians and their spouses during the previous year. The presentation was made at the annual meeting of the CMS Auxiliary to the University of Colorado School of Medicine, to be used as unrestricted grant funds. Contributions to

the AMA-ERF in 1979 totaled \$1,182,563, which was returned to states for distribution to their individual medical schools for use as unrestricted grants. Virtually all of these gifts came from the medical family and were recruited, in large part, by the American Medical Association Auxiliary. Needless to say, Colorado's sizable contribution was, for the most part, also recruited by members of the CMS Auxiliary.



# The treatment of chronic pain

H.G. Whittington, MD, Denver, Colorado\*

*Pain is an ancient medical concern, only recently considered a subject for full scientific investigation. With increasing knowledge of pain mechanisms, and practical experience in a variety of methods to ameliorate pain, there has been a rapid proliferation of pain treatment centers, with current estimates of 450 nominal pain centers operating in the United States. The practicing physician views these developments with some skepticism, and has understandable difficulty in deciding whether the pain center movement is valid or simply opportunistic profiteering on human misery. This report summarizes current experience with one pain treatment center in the Denver Metropolitan area.*

## **Background of the Denver Program**

The author arrived at his interest in chronic pain quite serendipitously. Over the years in private practice, an increasingly large percentage of his referrals came from physician colleagues, with the consequence that he began to see more and more psychosomatic, chronic stress, and chronic pain problems. The sequence in most of these patients was that at some point, usually after an exhaustive (and exhausting for the patient) series of tests, the individual was informed that there was no organic disease, that his problems were psychological, and that he should see a psychiatrist. Feeling accused and abandoned by his primary physician, the patient presented himself in the psychiatric office angrily, and with one goal foremost in his mind: to prove the referring physician wrong, to convince everybody that his problem was not "all in his head", but was a bonafide organic illness. In that emotional climate, successful psychotherapy is almost impossible, and rarely was the author able to establish a treatment alliance with these patients who were suffering greatly and obviously in need of medical attention.

At a meeting in 1976 of the Biofeedback Research Society, the author first heard C. Norman Shealy, MD, describe the Pain and Health Rehabilitation Center at LaCrosse, Wisconsin. He was impressed initially with the sophistication of the program design, which was sound from a social-psychological standpoint as well as medically and psychiatrically. Patients in that program were

never told that their problems were mental or emotional, and all services that might prove to be psychotherapeutic were delivered in some format other than standard, insight-oriented, dyadic psychotherapy. In addition, all safe and reportedly effective pain relief methods were used: transcutaneous electrical nerve stimulation, acupuncture, biofeedback, and a variety of mental control techniques organized into a systematic program called Biogenics™.

Subsequently, the author reviewed a number of other programs operating around the country. Some operating on a strictly behavioristic model reported impressively high success rates. However, only a small percentage of patients applying for services were accepted, and the majority was rejected as not willing or able to submit themselves to the rigorous program demands of a prolonged inpatient stay and involvement of family members. Most programs, however, operated in a quite reductionistic, conventional medical manner, with a variety of specialists taking their turn or "shot", at the patient.

After the patient completed this dreary round of specialist appointments, the physicians communicated with each other to a greater or lesser extent, and at some point the patient was told something about the outcome of the evaluation and treatment planning. Characteristically, the programs operated essentially on an "either/or" model: either the problem was organic, in which case drugs, nerve blocks, and/or surgery were indicated; or it was psychological, in which case psychotherapy and/or psychoactive drugs were recommended. These programs tended to be inordinately costly, and did not produce results commensurate with the investment of the patient's time, the patient's and the insurer's money, and the medical staff's best efforts.

Consequently, the author decided to initiate a program in Denver structured similarly to that undertaken by Dr. Shealy at the Pain and Health Rehabilitation Center in LaCrosse, Wisconsin. The Denver program opened in July 1978, and accepted the first group of patients in August. After an evaluation, patients who wish and seem likely to benefit are referred to a 12-day program, which is structured as an intensive, 8-hour-a-day experience. Patients return home at night, but the re-

mainder of the time participate in the program from 8:30 a.m. to 5:00 p.m. Patients who are addicted, or for other reasons need a tightly controlled milieu, are referred to an inpatient program in Boulder. Less seriously ill patients, who do not need the full 12-day program, are treated on an outpatient basis in a less intensive approach.

### ***Patient Characteristics***

During the 12-month period of time, 135 patients were evaluated by the author for chronic pain problems. The duration of pain ranged from 9 months to 43 years; the mean was 6 years. Sixty-one per cent of the patients complained of low back pain. The others had a variety of pains, including migraine headaches, peptic ulcer, irritable bowel, cluster headaches, peripheral neuropathy, causalgia, and neck and extremity pain. They had all received extensive and competent medical evaluation and treatment prior to being seen at the Pain Center. Most had had prior surgery, with the number of surgeries ranging from 1 to 32. Most of the patients were taking Valium, that ubiquitous and perfidious drug that is given so indiscriminately and so harmfully to chronic pain patients. The majority were habituated to their drugs and felt quite dependent upon them and unable to cope without them.

### ***Description of the Denver Program***

Two-and-a-half hours each day are spent in lecture seminars, which teach the patient about the anatomy and physiology of the nervous system, pain mechanisms, available pain relief techniques, the hazards of drug use, nutrition, stress and its management, exercise, family relationship problems, life planning, etc. An hour a day is devoted to stretching and limbering exercises. About four hours a day are spent in a series of mental training exercises called Biogenics™, to teach physiological self-regulation and pain control. Individual sessions are held with the patient, his spouse, and the couple or entire family. Somato-physiological procedures of known safety are utilized, including transcutaneous electrical nerve stimulation, acupuncture, local injections of Marcaine and/or Sarapin, medications, vitamins, and Tryptophan (an amino-acid precursor of Serotonin), as appropriate. The patient is withdrawn as rapidly as possible from analgesic, sedative and tranquilizing drugs. Physical therapy modalities, including therapeutic massage, are used. Spiritual counseling is also employed.

Forty-seven of the patients evaluated completed the 12-day program, with pre-and-post-treatment data available to evaluate the outcome. Two dropped out before completion, and three were asked to leave. Group followup is offered without charge once a month for a year, but less than half of the patients attend with any regularity. Individual appointments are scheduled as necessary for aftercare. Outcome is measured on five 100-point scales:

- Subjective discomfort
- Percentage of time pain is felt
- Percentage of reduction in activity level
- Effect on mood
- Drug use

At the end of 12 days, only 3 patients reported no improvement. Fifty-three per cent experienced from good to excellent pain relief. The mean pain profile score on admission was 325, on completion of the program, 224, a reduction of 31 per cent. While these results do not equal those reported by Shealy, whose program is quite similar, they represent a significant impact on a chronic, treatment-resistant population at a cost which is, by present-day standards, quite modest.

Many patients who report no lessening of severity or duration of pain nonetheless show increased activity level, improved mood, marked decrease in drug use, and a lessened reliance on medical services following completion of the program.

### ***Conclusion***

An holistic pain management program, utilizing many modalities but stressing patient responsibility in controlling pain, offered major pain relief to 53 per cent of patients in the initial sample. With continuing practice of the mental control devices taught patients, these results should improve over the subsequent months; a later paper will detail followup studies. ●

\*Dr. Whittington is Director, Denver Pain and Health Rehabilitation Center.

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With this issue of COLORADO MEDICINE we extend a belated "goodbye" to Abraham Kauvar, M.D., and former member of the Board of Directors of the Colorado Medical Society.

Effective October 1, 1980, Dr. Kauvar assumed the position of Director of Health and Hospitals for the city of New York. Dr. Kauvar resigned the same position with the city of Denver to accept the new post.

Dr. Kauvar was well known for his good works in the Society, in the medical profession and in the interests of public health and his city. His good works also reached abroad: Dr. Kauvar was invited to the state of Israel late in 1979 to review the needs of that developing nation for the delivery of health services. As a result of his consultations there, Dr. Kauvar was asked to return to Israel in 1980 to become one of a four-member team to implement his program of health services. Dr. Kauvar told COLORADO MEDICINE that the program in Israel was one of nationwide ambulatory care, as seen by a private practice physician. He said the program he designed was meant to take medicine out of the hospital and into the community. Israel has a state-operated health care service.

Dr. Abraham "Abe" Kauvar came on the Board of Trustees of Colorado Medical Society five years ago and admits he "had a chip on my shoulder because everybody was against Denver." Dr. Kauvar says that attitude has changed 180 degrees during the time he served on the CMS Board.

As for the post in New York, described as one of the toughest jobs in the United States, Dr. Kauvar said he just couldn't resist the challenge, adding, "Being in private practice, I think I'm going to (hopefully) do more than what is usual."

Best of luck to a good friend of the Society.

**DO YOU NEED A DOCTOR, A DENTIST, A PHARMACIST? PUEBLO COUNTY MEDICAL SOCIETY HAS THE ANSWER.**

The Pueblo County Medical Society, in cooperation with the Southeastern Colorado Dental Society and the Pueblo Pharmacal Association, has created a 24-hour a day, 7 days a week hotline for such emergency care or routine needs.

Called the "HEALTHLINE," the three Pueblo groups are providing the service to help Pueblo residents find a doctor, a dentist or a pharmacist whenever the need arises. Termed by some as a "mini-referral service," HEALTHLINE is fulfilling a need which is not limited to cities such as Pueblo. There are other such phone services operating in other parts of the state, but primarily for doctor referral. This is the first time, in recent years, that such a cooperative service has been offered in Colorado.

In Pueblo and environs you can call HEALTHLINE by dialing 543-1166.

**CHAMPUS ANNOUNCES CHANGES IN DEPENDENT MEDICAL BENEFITS**

Step-parents who are dependent on service members for more than one-half of their support may be extended medical benefits on a space-available basis at Uniformed Service medical facilities. Dr. John H. Moxley, Assistant Secretary of Defense for Health Affairs, announced the change in a recent memorandum, authorizing the Military Departments to expand their eligibility definitions for dependent parents to include dependent step-parents (and dependent step-parents-in-law). Changes in definitions for benefits will be published in future directives.

Dependents eligible for benefits under CHAMPUS, however, still include only spouses and children of service members -- not dependent parents (or step-parents).



## HEALTH ECONOMIST WARNS OF DRAMATIC CHANGES AHEAD IN HEALTH CARE FIELD

Eli Ginsberg, widely known health and medical economist, told members of the Colorado Foundation for Medical Care and Colorado Medical Society that many changes are upon the scene in health care. Ginsberg, a consultant to the federal government for 39 years in the Departments of State, Defense, Labor, HEW, GAO, as well as state and local governments and non-profit business organizations, says there are many changes coming in the service industry, of which health care is one of the largest. Ginsberg says the U. S. economy is becoming a 70% service economy. Ginsberg added: "I see a very large amount of noise in the system coming from nurses and other health practitioners. We know that it's going on between the ophthalmologists, the optometrists, the opticians and so on, and we know that there are judicial and other kinds of decisions." Ginsberg said it is already happening in some areas of nursing service, saying, "In San Francisco the nurses, to some extent, have reached a point where they will no longer be employees of the hospitals. They are free-standing professionals, and they sell their services to the hospitals the same way pathologists and radiologists do. The hospital has to make a contract with the nurse's association for coverage."

Dr. Ginsberg said "That's a whole new world, and I would suspect, from every thing I see on that front, that that pressure will be increasing from what I would call 'allied health' and from the nursing profession."

"It's the high cost of dying....."

Dr. Ginsberg told the physicians it's "not the high cost of medical care; it's the high cost of dying care, and that's a whole different matter." Ginsberg said medical care is not so expensive, by and large, but the high cost of dying is what is interesting, and he urged the medical profession to think its way though this matter of not being able to do anything except prolong life. That, he said, is where the high cost occurs in medical care.

"you ain't seen nothin' yet!"

Dr. Ginsberg ended by saying: "If you think the '70s have been difficult, you ain't seen nothin'! The '80s will be very much more difficult, inevitably, because the problems will be more difficult, because there will be more physicians; cost-containment we don't have any real answers to, and the competitors to physicians will be increasingly aggressive, and everybody is unhappy. Given the increase in the number of physicians, it is inevitable that the earnings of the individual physician will go down. That doesn't mean that the cost to the American people will go down, but the average earnings of the average physician can only go in one direction.....and that is down!"

### ARE YOU A USUAL, CUSTOMARY AND REASONABLE PHYSICIAN?

If you don't receive proper payment in the Medicaid program it may be that your office staff does not bill your "UCR" fee. Fees which are discounted in this program depress future remuneration.

Further, if the negotiating committee is to leverage a third Medicaid increase this year, they must have accurate charge data available., There is no reliable information on a naccurate percent of charge paid by Medicaid which differentiates medicine, anesthesia, surgery, radiology or pathology from one another. This currently precludes a reasonable allocation of any additional Medicaid dollars.

Instruct your staff to bill your usual, customary and reasonable fee!



# CONTINUING MEDICAL EDUCATION CALENDAR

PUBLISHED JOINTLY BY THE COLORADO FOUNDATION FOR MEDICAL CARE, COLORADO MEDICAL SOCIETY AND THE COLORADO ACADEMY OF FAMILY PHYSICIANS • 1601 EAST NINETEENTH AVENUE, DENVER, COLORADO 80218

## OCTOBER 1980

### 10th-11th

#### 6TH ANNUAL RURAL HEALTH CONFERENCE

-"Ourselves: The Best Alternative." Keystone, CO. Contact: Bob Bruegel, Office of Rural Health, Room 121, State Capital Building, Denver 80203. 839-2367. (Category 1 credits available)

### 12-18th

#### CLINICAL MANAGEMENT AND CONTROL OF TUBERCULOSIS.

National Jewish Hospital, Denver. Contact: Thomas Moulding, M.D., National Jewish Hospital & Research Center, 3800 E. Colfax Ave., Denver 80206. 388-4461, ext. 647. (48 hours of AMA Category 1 credit; 48 prescribed AAFP hours).

### 24th

#### PEDIATRIC/ADOLESCENT OB/GYN.

The Children's Hospital, Denver. Contact: Health Education Department, The Children's Hospital, 1056 E. 19th Ave., Denver, CO 80218. 861-6947. (AMA, AAFP credit available).

### 30th-December 18

**CONTROVERSIES 2:** An Ongoing Course in the Practice of Pediatrics. Contact: Health Education Department, The Children's Hospital, 1056 E. 19th Ave., Denver 80218. 861-6947. (AMA credit available on an hour-by-hour basis).

## NOVEMBER 1980

### 21st

#### PAUL R. HACKETT MEMORIAL PEDIATRIC ANESTHESIOLOGY SEMINAR.

Stapleton Plaza Hotel, Denver. Contact: Health Education Department, The Children's Hospital, 1056 E. 19th Ave., Denver, CO 80218. 861-6947. (AMA and AAFP credit available).

## JANUARY 1981

### 4th-11th

**FAMILY THERAPY, BEYOND INSTITUTIONAL CARE FOR SCHIZOPHRENICS, BRAIN AND BEHAVIOR—CLINICAL IMPLICATIONS OF RECENT RESEARCH.** 7 day Caribbean cruise. Contact: World Ports Travel, 7710 Ralston Road, Arvada, CO. 423-5338. (25 hours Category 1 credit toward AMA Physicians Recognition Award).

### 8th

#### NEUROPSYCHIATRIC GRAND ROUNDS.

Colorado State Hospital, Pueblo. Contact: Jay Scully, M.D., 1600 W. 24th Street, Pueblo, CO 81003. 543-1170. (APA approved for Category 1 credit).

### 8th-February 19

**CONTROVERSIES 2:** An Ongoing Course in the Practice of Pediatrics. Contact: Health Education Department, The Children's Hospital, 1056 E. 19th Ave., Denver 80218. 861-6947. (AMA credit available on a hour-by-hour basis).

### 17th-24th

#### HORIZONS IN SURGERY.

Vail. Contact: Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 E. 9th Ave., C-295, Denver 80262. 394-5241.

### 18th-23rd

#### THE YOUNG LUNG.

Aspen. Contact: Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 E. 9th Ave., C-295, Denver 80262. 394-5241.

### 25th-31st

#### CLINICAL MANAGEMENT AND CONTROL OF TUBERCULOSIS.

National Jewish Hospital, Denver. Contact: Thomas Moulding, M.D., National Jewish Hospital & Research Center, 3800 E. Colfax Ave., Denver 80206. 388-4461, ext. 647. (48 hours of AMA Category 1 credit; 48 prescribed AAFP hours).

## FEBRUARY 1981

### 23rd-27th

#### THE PEDIATRIC HEMATOLOGY-ONCOLOGY-IMMUNOLOGY POSTGRADUATE COURSE.

The Given Institute of Pathobiology, Aspen, CO. Contact the Office of Postgraduate Medical Education, The University of Colorado School of Medicine, 4200 East Ninth Avenue, Denver 80262, or call (303) 394-5241. (20 Category 1 hours credit).

## MARCH 1981

### 9th-13th

**HIGH-RISK INFANT CARE.** Denison Auditorium, University of Colorado School of Medicine, Denver, CO. Contact the Office of Postgraduate Medical Education, The University of Colorado School of Medicine, 4200 East Ninth Avenue, Denver 80262, or call (303) 394-5241.

## **RUMACK NAMED PRESIDENT-ELECT OF NATIONAL POISON CONTROL GROUP**

Dr. Barry Rumack, associate professor of pediatrics, University of Colorado School of Medicine, and director, Rocky Mountain Poison Center, has been named President-elect of the American Association of Poison Control Centers.

A graduate of the University of Wisconsin School of Medicine, Dr. Rumack joined the CU medical school faculty in July, 1974. He has been director of the poison center since January, 1974.

He is a member of several state and national committees, including the Colorado State Board of Health, Colorado State Committee on Poison Control and the Consumer Products Safety Commission's Toxicology Advisory Board.

Dr. Rumack has also authored more than 100 publications and serves on several editorial boards.

## **ARMY RESERVE ANNOUNCES NEW BENEFITS FOR MEDICAL STAFFING**

Doctors and medical students now have their own personnel counselor for explaining professional benefits available through the United States Army Reserve. Major Mary Lou De Zeeuw is one of 23 Army reservists who have been called to active duty to help attain the Surgeon General's goal of staffing medical positions in the United States Army Reserve units.

Major De Zeeuw tells COLORADO MEDICINE that opportunities now include up to \$4,000 for medical school assistance, funded continuing medical education opportunities (professional meetings), liability protection while serving in the Army Reserves, \$20,000 worth of life insurance, and Commissary and Post Exchange privileges.

If you are interested in additional information, contact Major De Zeeuw at 341-3889. She'll be available to further explain the Army Reserve benefits.

## **NEW CARCINOGEN INFORMATION PROGRAM ESTABLISHED TO EDUCATE PUBLIC ABOUT HAZARDS**

The Center For The Biology of Natural Systems, Washington University, St. Louis, Missouri, announces that it is offering a bulletin concerning the dangers of asbestos. The Center points out that, generally, published information about cancer and its causes is written for other scientists or doctors and not for the general public. The Center is making available a bulletin, the "Carcinogen Information Program," to bridge the gap between the scientific journals and the general public.

The CIP Bulletin is available at no cost by sending a long, self-addressed, stamped envelope to CIP, Washington University, Campus Box 1126, St. Louis, Missouri 63130.

## **SPORTS MEDICINE GAINS ATTENTION AS WINTER AND SKIING APPROACH**

The Rocky Mountain Chapter of the American College of Sports Medicine will hold its winter meeting on December 5th and 6th at Devil's Thumb Cross Country Ski Ranch at Fraser, Colorado. Topic of this year's meeting will be "Skiing Injuries."

For information on the conference meeting, contact Jack Harvey, M.D., Director, Fort Collins Sports Medicine Clinic, 1148 E. Elizabeth, Fort Collins, Colorado 80524.



## Non-Medical Application of Drugs Continues to Threaten Colorado

Should Colorado optometrists be granted, by legislative fiat, authority to administer drugs to their customers for purposes of detecting the presence or absence of glaucoma, diagnosis of eye disease or even treatment of medical eye problems?

If this question appears to be preposterous to the medical community in Colorado, it shouldn't. Legislation was introduced in the Colorado General Assembly in 1978 which, if passed, would have authorized optometrists, non-medical practitioners, to use pharmaceutical agents during routine visual examinations for purposes of refraction.

Even more surprising is the fact that the bill passed the Colorado House of Representatives after a 41 to 22 vote in favor of that crucial amendment. It wasn't until the bill was considered by the Senate Health, Education and Welfare Committee that the Colorado Ophthalmological Society was successful in convincing members of the committee that optometrists are not trained or educated in the use of drugs that it was killed by a 7 to 1 vote.

Colorado Ophthalmologists fully anticipate that optometrists will repeat the attempt to scale the so-far unscalable heights by once again introducing drug legislation in the 1981 General Assembly. Who will introduce such legislation and whether the bill will start in the House or the Senate is not yet known.

Whether the Colorado Optometric Association is successful in its attempt to gain use of pharmaceutical agents for its members in their practice of vision care will depend greatly upon the resolve of the entire medical community of Colorado in addressing such an issue in the legislature.

Let's face it, the success or failure of optometric drug legislation will be directly proportionate to the time and effort that medical doctors are willing to spend in personal contact and education of state legislators.

If optometrists are permitted the use of drugs in vision care, which allied health care group will be the next to try to grab at the brass ring in the legislative arena.

**J. Gregory Baron, MD**  
Colorado Springs, Colorado

## BETH ISRAEL CONFERENCE PROGRAM 1981 WINTER SCHEDULE

### February 7-14, 1981

Third Annual Vail Emergency  
Medicine/Critical Care Conference  
*The Mark Resort, Vail, Colorado*

Second Annual Vail General Dentistry  
Conference  
*Lion Square Lodge, Vail, Colorado*

### February 14-21, 1981

Seventh Annual Vail OB/GYN Conference  
*The Mark Resort, Vail, Colorado*

Sixth Annual Vail Psychiatry Conference  
*Lion Square Lodge, Vail, Colorado*

Third Annual Vail Geriatric  
Medical Conference  
*The Lodge at Vail, Vail, Colorado*

### February 21-28, 1981

Eleventh Annual Aspen Radiology Conference  
*Aspen Institute for Humanistic Studies*

Second Annual Vail Pathology Conference  
*Kiandra-Talisman Lodge, Vail, Colorado*

### February 28-March 7, 1981

Fourth Annual Vail Cancer  
Treatment Conference  
*Kiandra-Talisman Lodge, Vail, Colorado*

Third Annual Vail Sports Medicine Conference  
*Lion Square Lodge, Vail, Colorado*

### March 7-14, 1981

Sixth Annual Vail Family Practice Conference  
*The Mark Resort, Vail, Colorado*

Sixth Annual Vail General Surgery Conference  
*Lion Square Lodge, Vail, Colorado*

Fourth Annual Vail Urology Conference  
*Kiandra-Talisman Lodge, Vail, Colorado*

### March 14-21, 1981

Sixth Annual Vail Internal Medicine  
Conference  
*Lion Square Lodge, Vail, Colorado*

Third Annual Vail Pediatrics Conference  
*The Mark Resort, Vail, Colorado*

Second Annual Vail Clinical  
Brain Conference  
*Kiandra-Talisman Lodge, Vail, Colorado*

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## Council on Professional Education

Highlights of Minutes of Meeting  
July 29, 1980

Council was asked by the Colorado Medical Society Board of Trustees to present a formal report to the Board on the validity of the Colorado Consortium for Continuing Medical Education. The Consortium is funded in part by the Colorado Medical Society. After discussion, the Council unanimously voted to approve a resolution "that the Colorado Medical Society continue to support and sponsor the Colorado Consortium for Continuing Medical Education, both philosophically and financially, while the CCCME searches for supplemental funding."

Council also approved five other resolutions for consideration by the House of Delegates at the 1980 Annual Session: 1) Role of CMS in Scientific Education, 2) Accessibility of Accredited CME, 3) Re-establishing a Single National CME Body, 4) CMS Support for the UCSM, and 5) Services by AMA to support CMS.

Council was presented with complimentary advance copies of the Physicians' Personal Continuing Medical Education Record Folder, which has since been distributed to the Colorado membership of the Society as a service of the Council and CMS.

Dr. Mueller told the Council he had asked the President-elect of the Society to replace him as Chairman of the Council in September. Dr. Patrick Moran will be asked by the President-elect to chair the Council.

Next meeting will be the third week in November, the date to be set by the Chairman.

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## new members

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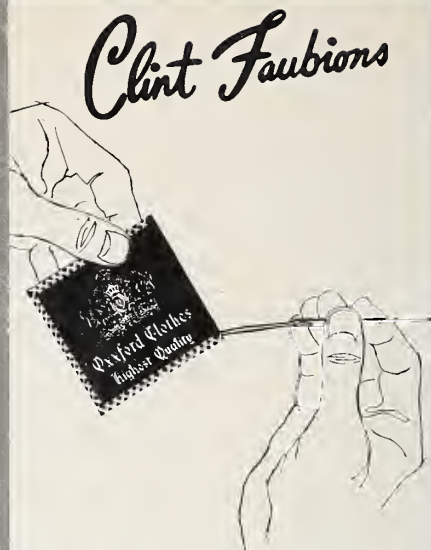
**Adams County-Aurora Medical Society:** Joe M. Sanders, Jr., MD, Donald R. Moffitt, MD, David W. Wells, MD.

**Denver Medical Society:** Gerald Goldstein, MD, Maurice E. O'Connor, MD, Herbert J. Thomas, III, MD.

**La Plata County Medical Society:** Oscar G. Fischer, MD, Phil C. Pearson, MD, Paul R. Kuetter, MD, Everett R. Castle, MD, Robert F. Goodman, MD.

**Mesa County Medical Society:** Craig A. Spoering, MD.

**Boulder County Medical Society:** David A. Lavrinta, MD.



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## CME Handbook—A Review

This summer the Colorado Consortium for Continuing Medical Education published the *Continuing Medical Educators' Handbook*. The August issue of the *AMA Continuing Medical Education Newsletter* carried the following review of the Handbook. Editor of the *AMA Newsletter*, and author of the review, is MARVIN E. JOHNSON, M.D., known to many Denver physicians as a surgeon in private practice and as a member of the staff of St. Joseph Hospital.

A "Continuing Medical Educators' Handbook," designed for the community-based physician who has continuing medical education responsibilities, has just been published by the Colorado Consortium for Continuing Medical Education. This book is most timely, considering the decided trend for an increasing number of physicians to obtain a significant share of their CME in their own home hospital. This increasing utilization is putting additional demands upon the time of the practitioner turned educator and the practitioner/part-time educator. This Handbook will be of immense assistance to them because it is practical and oriented to educational activities in the community hospital.

The subjects covered are: assessing educational needs; preparing and using behavioral objectives; improving methods of teaching and learning; evaluating the instructor; assessing the im-

pact of education on participants; preparing and using visual aids; and using patient data systems in CME.

Chapter 8 of the Handbook, the final chapter, consists of annotated bibliographies of books, journals, and articles that are carefully selected to aid the physician-educator. There is in addition a section on other resources indicating where the reader can go for specific help. A separate listing is given for each of the preceding seven chapters of the Handbook so that easy accurate reference is possible.

Eight authors, each experienced in continuing medical education, have contributed their expertise to the Handbook. The editor, Kevin P. Bunnell, EdD, Executive Director of the Colorado Consortium for Continuing Medical Education, is thoroughly knowledgeable in both the educational component and the administrative aspects of continuing medical education. The Consortium is composed of the Colorado Medical Society, the University of Colorado Health Sciences Center, and Colorado Foundation for Medical Care. This excellent 70-page Handbook, priced at \$9.00, is certainly a value. It will undoubtedly contribute to the improvement of many hospital programs and represents a real contribution to the field of CME (Editor's Note).\*

\*"Reprinted with the permission of the American Medical Association."

## CME Record File

A *Personal Continuing Medical Education Record* file was mailed to every CMS member in Colorado during the week of August 4th. Physicians are encouraged to use the file to keep track of their CME hours for BME licensing requirements or the Physicians' Recognition Award.

The blue and white folder was mailed to the membership as a service of the Council on Professional Education.

The file comes with a pad of simple forms for recording the physician's participation in individual educational events. The pads are included as a sample, and may be copied as needed.

Physicians using the file should note that a summary of the Board of Medical Examiners regulations on educational requirements for relicensure appears on the back of the record file.

Physicians with questions about the file or who did not receive one, should call Kevin Bunnell, director, Division of Continuing Education, at 861-1221 x 262, or 1-800-332-4150 x 252.

## DMS Annual Meeting Set

October 7, 1980 is the date of the Annual Meeting of the Denver Medical Society. Dr. Edward A. Rhodes completes his term of office and the new president, orthopedic surgeon J. Phillip Nelson, M. D., takes over for the 1980-1981 term.

The meeting takes place at the Kent Room of the DMS Building in conjunction with the regular October meeting of the DMS Council and a social hour of food and refreshment.

A special Annual Report of activities for the year is printed and distributed to the attendees and later mailed to all DMS members. In addition to addresses by the outgoing and incoming presidents during special ceremonies, 50-year physicians are honored, reports are presented on any special projects and, this year, plans include the presentation to the Society of a special color portrait of the late Dr. Ward Darley, former member, renowned educator and dean of the University of Colorado School of Medicine, for mounting in the building.

Doctor **Stanley John Sontag** of Lakewood, Colorado died August 21, 1980 of injuries in an automobile accident.

Doctor Sontag was born September 7, 1920 at Mankato, Minnesota, and received his MD at the University of Minnesota in 1948, and was licensed to practice in Colorado in 1949.

Doctor Sontag interned at St. Luke's Hospital, Denver, from July 1948 to July 1949. He practiced Family medicine in Lakewood since that time.

Doctor Sontag served in the Army Medical Corps during the war in Korea.

He was a member of the Colorado and Clear Creek Medical societies, and of the American Association of Family Practice.

He is survived by three daughters, Mrs. Anna Marie Gonzales, California; Eugenie C. Sontag, Denver, and Lucia E. Johnson, Massachusetts. Two brothers, Walter and Wilfred, both of Mankato, also survive, as do three sisters, Mrs. Hildgard Oberg and Mrs. Florence Blank, both of Mankato, and Mrs. Theresa Irma Darrow, San Diego, California.

Mrs. Sontag preceded Doctor Sontag in death in 1972. She had been a leader in volunteer hospital work and nursing home administration.

Doctor **William Carl Shontz** died in Pueblo on August 16 at the age of 62.

Doctor Shontz was born in Pueblo on March 27, 1918. He received his BA at the University of Colorado in 1940, and in 1943 received his MD. From January 1944 until October he interned at Colorado General Hospital in Denver, then served as a Captain in the Army Medical Corps with the 307th General Hospital Unit until 1946.

From 1946 until 1948 he had first a General Practice in San Luis, Colorado, then a Urology practice in Pueblo. From December 1948 until July 1949 he served at Colorado State Hospital, and from July 1949 until December 1951 he was on the staff of Corwin Hospital as Urologist.

Doctor Shontz established a practice in Urology with Drs. Wesley Boucher and Milo Gerber. He was on the staff at St. Mary-Corwin Hospital until his retirement.

He was a member of the Pueblo and Colorado Medical societies, and of the American Urological Association.

He is survived by Mrs. Helen A. Shontz, and two daughters, Sharon Shontz, Denver, and Mrs. Suzanne Pickrel, Omaha, Nebraska, and by a half-brother, Patrick O'Donnell, Vancouver, British Columbia.

Doctor **Otto John Klunder** died in Denver August 16, 1980 at the age of 59.

Doctor Klunder had practiced anesthesiology in Colorado since receiving his license here in 1949.

He was born in Gary, Indiana on August 23, 1920. In 1943 he received a BS from St. Ambrose College in Davenport, Iowa, and in 1946 received his MD from the University of Iowa. He interned at St. Luke's Hospital, Denver, and from July 1, 1950 until July 1, 1952 held a residency at Columbia-Presbyterian Medical Center in New York City.

He practiced in Frederick, Colorado from September 1949 until January 1950 when he moved to Brush until going to New York in July 1950.

In 1956 he was Certified by the American Board of Anesthesiology. He was a member of the Colorado and Denver Medical societies and of the American Medical Association. He belonged to the Colorado Society of Anesthesiologists which he served as vice president in 1959.

From September 1947 until September 1949 he served as a Captain in the Army Medical Corps.

Doctor Klunder is survived by his widow, Mrs. Florence G. Klunder, and by four daughters, Mrs. Trish Cavins, Mrs. Kathy Bressette, Mrs. Sharon Tobin, and Mary Klunder, of Denver, and by three sons, Robert, John, and David, also of Denver.

Two sisters, Mrs. Berniece Tattersfield, Pompano Beach, Florida, and Mrs. Sylvia Harms, Coal Valley, Illinois also survive.



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### THE COVER

Our cover this month represents many new aspects of the *COLORADO MEDICINE* effort to communicate, to condense, to get to the point, and to give the reader the opportunity to be selective about his or her reading. During the coming months of publication, *COLORADO MEDICINE* will attempt to streamline its presentation of meaningful news in an easy-to-absorb manner to accommodate busy professionals. Of paramount interest to every CMS physician member is the Hartford Story which you'll find in our "At Press Time ..." section.

Address all correspondence relating to subscriptions, advertising or address changes, manuscripts, organizations and other news items relating to editorial content to Editorial and Business Office.

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*Colorado Medicine* (ISSN-0199-7343) is published monthly for \$12 per year by the Colorado Medical Society, 1601 East 19th Avenue, Denver, Colorado 80218. Second-class postage paid at Denver, Colorado. POSTMASTER: Send address changes to *Colorado Medicine*, 1601 East 19th Avenue, Denver, Colorado 80218.

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## FOUNDATION COORDINATES PHYSICIAN INPUT TO HSAs

By Rachelle Kaye, Director of Program Planning  
and Criteria, Colorado Foundation for Medical Care

Federal intervention in medicine is a reality for the modern physician and is not likely to disappear. In fact, all of the indication are that it will increase.

The Health Planning and Development Legislation which established HSAs (Health Systems Agencies) and SHPDAs (State Health Planning and Development Agencies) is a good example of this. The activities of these agencies can directly impact the resources available to physicians in caring for the patients by virtue of their power to approve or deny the development of new services in a given geographical area of the state, and potentially, their power to eliminate existing services which are determined to be "inappropriate". On the positive side, HSAs can stimulate the development of health care services in underserved areas where such resources are desperately needed.

Because the activities of HSAs and the SHPDA can so directly affect the practice of medicine, the Colorado Foundation for Medical Care and the Colorado Medical Society have taken the position that strong physician input into all aspects of the planning process is critical and the Foundation has undertaken the responsibility of coordinating systematic, organized physician input into HSA AND SHPDA activities. The Health Care Standards Committee, which is comprised of appointed representatives from all specialty and subspecialty societies in the state, will be utilized as the "Steering" Committee for this activity. It will also provide for specialty input into the process. Additionally, the Foundation's Regional Councils, which are comprised of appointed representation from each component medical society in the state, will provide local input into planning activities. The Foundation is closely coordinating all of these activities with the Colorado Medical Society.

The Foundation will utilize its current staff, which includes a health planning coordinator whose responsibility is exclusively the coordination of physician input into health planning, to monitor all HSA and SHPDA activities and alert organized medicine to major issues and concerns. Physician responses will then be directed to the relevant HSA and the SHPDA. The Colorado Foundation for Medical Care and the Colorado Medical Society will work together

to provide a single yoke representing physician input. This cooperative effort has been approved by the CFMC Board of Directors and the CMS House of Delegates at its recent Annual Session.

An example of a successful effort which has already been completed was the 1980 State Health Plan. Chapters of the State Health Plan were sent to the appropriate specialty representatives of the Health Care Standards Committee for review and comment. The comments of the Health Care Standards Committee members were then directed to the SHPDA and were presented to the Plan Development Subcommittee of the State Health Coordinating Council (SHCC). The majority of the comments resulted in some modification of the State Health Plan chapters of concern.

The Foundation is currently in the process of coordinating physician input into new drafts of Health Systems plans being developed by the HSAs and review of certificate of need application notices. The major activity of concern in the coming months will be Appropriateness Review and all specialty and component societies need to be aware of this activity. Under law, the HSAs are mandated to perform appropriateness review of the health care services in their health service areas. This includes an assessment of the appropriateness of a given service in terms of its:

- availability
- accessibility
- acceptability
- continuity
- cost
- quality

The schedule of services to be reviewed include the following:

- End Stage Renal Disease, which is currently under review.
- CT Scanning
- Cardiac Catheterization and Open Heart Surgery starts 12/11/80
- Radiation Therapy
- Long Term Care Services starts 6/11/80
- Home Health Care Services
- Emergency Medical Services starts 12/11/81
- Critical Care Services
- General Medical/Surgical Services

Continued on page 405



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## "CLINICAL TOPICS FOR CME PROGRAMS" NOW AVAILABLE

A new planning tool and source of information for Colorado Directors or Coordinators of continuing medical education is now available.

The Colorado Consortium for Continuing Medical Education (CCCME) distributed its booklet, "Clinical Topics for Continuing Medical Education Programs" in mid-October to Directors of CME in all CMS-accredited Colorado hospitals and specialty societies. The booklet lists clinical topics from sixteen specialty societies with a brief description of each topic, and the name of a contact person from each society who will help educators or physicians interested in receiving consultation to get in touch with the speaker/consultant. Also, if an educator or other interested physician desires a talk or consultation on a subject **not** listed, the contact person will help him find a speaker or consultant within that specialty.

 Colorado  
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Continuing Medical Education

### DIRECTORY OF CLINICAL TOPICS

FOR

Continuing Medical Education Programs

a joint project of  
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University of Colorado  
School of Medicine  
Colorado Foundation for Medical Care

The booklet is available free of charge to educators, rural physicians and anyone else interested. Please direct written or phone inquiries to: Kevin P. Bunnell, Ed.D., Executive Director, CCME, 1601 E. 19th Avenue, Denver, Colorado 80218, 861-1221 x 262 (outside the Denver metro area dial toll-free 1-800-332-4150 x 262).

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As early as 1926, the AMA House of Delegates stated that "no undue obstacles should be placed in the way of foreign physicians of known qualifications who desired particularly to secure graduate medical education in this country."

Following World War II, the AMA urged that suitably qualified physicians of foreign origin should be assimilated into U.S. medicine. Following the adoption of a student-exchange program by the U.S. Congress, the AMA House of Delegates stated "that foreign trained physicians should be considered for appointment as interns in approved hospitals only when: (1) language difficulties do not seriously impair the program; (2) the same educational standards applied to graduates of foreign schools as to graduates of approved American medical colleges; and (3) the appropriate state licensing board approves." (December, 1954)

Since then, FMGs (foreign medical graduates) from all over the world entered many graduate training programs. Some of them returned to their countries or origin, but many of them preferred to live and practice in this country, made possible by changes in immigration laws. These FMGs organized their own ethnic groups or organizations to discuss their mutual problems and interests and to socialize. Very few FMGs joined organized medicine.

Now there are problems unique to the FMG in the United States—problems which we must deal with today and probably for a long time to come.

Justifiable concern is promoting the involvement of foreign physicians in organized medicine, in leadership in the FMG community, and their assimilation into the general mainstream of American life. Once these needs are met, FMG identification with organized medicine will result.

As of January, 1978, there were 87,000 foreign medical graduates in the United States. Approximately 74,000 of that group hold full and unrestricted medical licenses in at least one state. Of these, somewhat more than one third are members of the American Medical Association. This is a low figure, since the average foreign physician would be expected to be well-disposed toward joining the ranks of organized medicine. The problem is that he has not been approached and recruited. At a time when membership recruitment efforts have become so very important, a substantial membership market is being overlooked.

A desire for active identification with and participation in the activities of organized medicines must be created in the mind of the FMG. One way to do this would be by involving FMGs personally in society activities through its many councils, committees, and programs. The effect on this would be threefold: it would demonstrate good will on the part of organized medicine; and it would foster the development

of medical statesmen among this group of physicians. This would ultimately encourage individual membership.

The absence of participation that now exists reflects a need for FMG leadership at all levels of organized medicine. There seems to be a lack of understanding on the part of FMGs of their role in organized medicine. With involvement will come an awareness of the important role they can play, and of the opportunities for them present in national, state, and county medical associations.

While there are very particular FMG needs to which organized medicine must become sensitive, the major problems facing FMGs in this country are the same issues affecting all practicing physicians in the 1980s. Increasingly, legislation and regulation affects every physician. Providing thorough, conscientious medical care is the physician's primary safeguard against the adverse encroachment of government regulation. However, it is through the efforts of organized medicine that the most active and effective means of preserving physician freedom actually occurs. All physicians will want to and need to support this endeavor. The medical profession needs it leaders—yes, new leaders, and there is a great potential for leadership among FMGs within organized medicine.

Active involvement will facilitate the integration of these two medical communities. This goal of assimilation is in the spirit of the historical development of FMG activity in this country. In 1957, the Educational Council for Foreign Medical Graduates required that FMGs hold an ECFMG certificate. In 1962, the AMA appropriated \$90,000 to the Cuban Medical Association for the purpose of assisting Cuban physicians to qualify as American medical practitioners. Later, in 1970, orientation programs designed to remedy cultural and language deficits were made a part of the residency programs having FMGs. The Fifth Pathway program instituted in 1971, gave students who had attended U.S. undergraduate colleges, and then graduated from foreign medical schools, the opportunity to take a year of supervised clinical training in the U.S. or Canadian medical schools, instead of fulfilling the internship requirement of the foreign country. At the 1975 AMA clinical meeting, a report was adopted which, among other recommendation, called for the "improvement and strengthening of international relations of the United States by promoting better mutual understanding among the peoples of the world through educational and cultural exchanges."

It was at the AMA Annual Convention in 1977 that the House of Delegates referred Resolution 115 to the Board of Trustees. The resolution requested that the AMA establish a committee for foreign medical

Continued from page 386

graduate affairs and the problems involved in FMG migration. After careful consideration of the resolution, the AMA established an Ad Hoc Committee on FMGs to develop "a program which will deal directly with the problems confronting foreign graduates in the United States." The Committee felt it was necessary to open its deliberations to the various organizations affecting the FMGs; among these were included the Educational Council for FMGs, the Immigration Department, the Federation of State Licensing Boards—and more important, to open the discussions to the FMGs themselves. As a result, an "Open Forum" format was developed to consider several central subject areas, such as the effect of current manpower legislation on FMGs, the problems of FMGs in residency training, qualifying examina-

tions, and licensure. These concerns were given careful consideration at five "Open Forums" held in St. Louis, New York City, Miami, Los Angeles, and Chicago.

In conclusion, it is the responsibility of organized medicine to not only make itself available, but also to become relevant and important in the life and work of every foreign-trained physician. Likewise, it is the responsibility of every FMG to share in the opportunities, challenges, and efforts of the evolving medical community.

DATTATRAYA G. LANJEWAR, M.D.  
956 Split Rock Road  
Pelham Manor, N.Y. 10803

**EDITOR'S NOTE:** The guest editorial is reprinted from the New York State Medical Society Journal, and was written by Dr. D. Lanjewar, a delegate nominee of the New York State Medical Society to the AMA House of Delegates.

AMA recently emphasized the importance of the role that Foreign Medical Graduates play in organized American medicine, and the AMA is especially interested in encouraging FMGs to become active in organized medicine.

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# **Your Dollar In Professional Liability Insurance..... A Part of Which You're Getting Back (Cover Story)**

The Hartford Insurance Group is making a refund of \$1,050,205.00 to the members of Colorado Medical Society insured by The Hartford.

Why the rebate? A good question! Because you, as an insured member, have helped reduce your malpractice risk in Colorado. The refund is based on a contractual agreement between Colorado Medical Society and The Hartford. The agreement stems from the Society's risk management program to help its members prevent malpractice incidents. Each time a malpractice incident does not result in a claim filed, the insured group's risk reserve is reduced. Because of the risk management practices used in Colorado, CMS members insured by The Hartford are seeing a part of their premium dollar returned to them.

Malpractice insurance coverage is only a small part of the number of services provided physician members by Colorado Medical Society, but the importance of this service is highlighted by the fact that members of CMS are afforded a much more liberal insurance coverage for much less premium payment.

James W. Webb, Assistant Secretary in The Hartfords Casualty Special Risk Department said, "The Colorado Medical Society recognized that it must take an active role in improving the quality of health care in Colorado and in helping physicians prevent malpractice claims."

Colorado Medical Society is continuing to work on changes in the professional liability coverage for its members, providing the most economical, best administered program of professional coverage in the United States. The CMS/HARTFORD malpractice insurance is an "occurrence" type policy which, in the long run, is much less expensive than the "CLAIMS MADE" type insurance policy for a number of reasons: (1) physicians can leave the malpractice insurance program offered by CMS at any time, and their premium payment stops at that point, but their insurance coverage continues up to the date that the practice stopped. This is opposed to continuing to pay premiums for "CLAIMS MADE" policies years after the physician quits his practice or moves, which often results in double payment for single coverage; (2) the CMS program of stemming malpractice insurance claims has paid off by reducing the dollar amount of insurance reserves, meaning that CMS members have reduced their "at risk" amount; (3) the administration and expert legal service provided through The Hartford policy are efficient and proven, again reflected in the reduction of malpractice claims and return of your premium dollars.

What it all boils down to is that CMS is providing its members with a high quality "occurrence" malpractice insurance, but at much lower rates in terms of service received and premium reduction.

At press time, final distribution of the \$1,050,205.00 rebate was still being finalized in the matter of amounts and sending out of actual rebate checks.

# **Council on Public Health**

## **Minutes of Meeting,**

### **Wednesday, Oct. 8, 1980**

MEMBERS PRESENT: DRS. GIERINGER, JOHNSON, NELSON, STUTZMAN, TOLD, DOSTER, CHAIRMAN.

MEMBERS ABSENT, UNEXCUSED: DR. DAVIS, QUINN, SBARBARO.

OTHERS PRESENT: JOHN G. MCFEE, M.D., CHAIRMAN, COMMITTEE ON MATERNAL AND INFANT HEALTH; ROGER S. MITCHELL, M.D., ENVIRONMENT; THOMAS M. VERNON, M.D., CO DEPT. OF HEALTH; WILLIAM R. HENDEE, PH.D., PROF. AND CHAIRMAN, RADIOLOGY, U.C. MED. SCHOOL; ROBERT SCHLAGETER, ENVIRONMENTAL DIVISION, CO DEPT. OF HEALTH AND CO DEPT. OF PUBLIC HEALTH ASSOCIATION; CYNTHIA AND MEL KESSLER, RESIDENTS OF CONIFER WITH CONCERN ABOUT SEVIN-4-OIL; BRIAN STUTHEIT, GINNIE TORREY, CMS.

DIGEST OF MINUTES: DR. DOSTER ASKED THE PARTICIPANTS TO INTRODUCE THEMSELVES AND OPENED THE MEETING WITH INFORMATION FOR MEMBERS CONCERNING THE COUNCIL'S REPRESENTATION THROUGH HER MEMBERSHIP ON THE DEPT. OF HEALTH'S HEALTH PROMOTION/RISK REDUCTION CONSORTIUM, THE NEWS THAT HB/RES 18, ELIMINATING SMOKING FROM OFFICIAL FUNCTIONS OF THE CMS WAS ADOPTED BY THE HOUSE AT AS '80, AND THAT THE PRESIDENT'S PLANNING SESSION, 1980, IDENTIFIED THE SUPPORT OF PATIENT SELF-RESPONSIBILITY THROUGH EDUCATION AS ONE OF THE 10 TOP GOALS OF CMS IN THE COMING YEAR.

DR. BILL HENDEE REQUESTED THE COUNCIL'S ATTENTION TO TWO SIMULTANEOUS PROBLEMS WHICH AFFECT HEALTH CARE IN COLORADO: 1) THE PUBLIC'S ESCALATING CONCERN ABOUT LOW LEVEL RADIATION WHICH HAS PRODUCED A NEED FOR AN EDUCATIONAL PROGRAM FOR



COLORADO PHYSICIANS ON THE TOPIC OF LOW LEVEL RADIATION EXPOSURE AND 2) THE IMPENDING NATIONAL CRISIS REGARDING THE DISPOSAL OF RADIOACTIVE WASTE WHICH WILL SERIOUSLY AFFECT NUCLEAR MEDICINE. ACTIONS: THE COUNCIL AGREED THAT IN THE AREA OF EDUCATION IT WOULD SUPPORT 1) SUBMISSION OF AN ARTICLE BY DR. HENDEE TO THE EDITORS OF COLORADO MEDICINE REGARDING THE NEED FOR PHYSICIANS TO BE INFORMED, THE AVAILABILITY OF SPEAKERS FROM THE MEDICAL SCHOOL WILLING TO ATTEND COMPONENT SOCIETY MEETINGS AS WELL AS SLIDE PROGRAMS, SOME BEING PUT TOGETHER BY THE SOCIETY OF NUCLEAR MEDICINE AND OTHERS UCHSC PRODUCED, WHICH COULD BE PRESENTED TO HOUSESTAFFS BY LOCAL RESOURCE PHYSICIAN-SPEAKERS 2) A LETTER TO BE REVIEWED BY THE COUNCIL IN WHICH DR. HENDEE WOULD OFFER SPEAKERS AND PROGRAMS TO FILL THE NEED FOR EDUCATION TO COMPONENT SOCIETY PRESIDENTS 3) THE POSSIBILITY OF TELEVISION APPEARANCES BY DR. HENDEE. REGARDING THE DISPOSAL SITE CRISIS, THE SUBJECT OF RECENT ADOPTED AMA RESOLUTION 82, THE COUNCIL VOTED UNANIMOUSLY TO PROPOSE THAT BOARD OF DIRECTORS OF CMS SEND A LETTER TO GOVERNOR LAMM ASKING FOR ATTENTION TO THE PROBLEM NOT IDENTIFYING THE SOLUTION. DR. HENDEE WILL DRAFT A LETTER, TO BE REVIEWED BY BRIAN STUTHEIT AND DR. VERNON, PASSED ON BY DR. DOSTER AND THE COUNCIL, AND THEN SUBMITTED TO THE BOARD WITH THE COUNCIL'S RECOMMENDATION.

MRS. CYNTHIA KESSLER ASKED THE COUNCIL TO REVIEW HER COMPENDIUM OF RESEARCH CONCERNING THE HEALTH EFFECTS OF SEVIN-4-OIL, A PESTICIDE USED IN FORESTED AREAS. USE IS LIMITED IN MAINE TO AREAS REMOVED BY A 3-MILE BUFFER ZONE FROM HUMAN HABITATION BECAUSE OF CONCERN ABOUT SEVIN-4-OIL'S EFFECTS. IN LIEU OF RECAPITULATION, MRS. KESSLER'S RESEARCH IS INCLUDED WITH MINUTES. ACTIONS: THE COUNCIL AGREED UNANIMOUSLY TO INVITE TED DAVIS OF THE CO DEPT. OF HEALTH AND DR. JIM TODD OF EPA TO PRESENT THEIR VIEWS AT THE NEXT MEETING, TO WHICH MR. AND MRS. KESSLER ARE ALSO INVITED.

WOMEN'S HEALTH NEEDS: THE COUNCIL DISCUSSED THE PRESENTATION OF A PROGRAM FOR THE PUBLIC DEVOTED TO THE HEALTH NEEDS AND CONCERNS OF WOMEN. THE PROGRAM WOULD BE A PROJECT OF THE COUNCIL TO BE UNDERTAKEN AS A POSITIVE STEP IN THE AREA OF ENCOURAGING PATIENT SELF-RESPONSIBILITY, GOAL 7 OF CMS. ACTIONS: IT WAS AGREED THAT THE PROJECT CONCEPT WOULD BE DISCUSSED WITH MRS. THOMPSON, PRESIDENT OF THE CMS AUXILIARY, AND THAT DRS. DOSTER AND NELSON WOULD INVESTIGATE THE INTEREST OF THE MEDICAL WOMEN'S ASSOCIATION. THE COUNCIL IS INTERESTED IN PURSUING THE PROJECT IF THERE IS INDICATION OF SUFFICIENT INTEREST AMONG CMS MEMBERS WHO WOULD BE CALLED UPON AS SPEAKERS AND AMONG THOSE GROUPS AS WELL, E.G., LEAGUE OF WOMEN'S VOTERS, CMS AUXILIARY, FROM WHOM REGISTRANTS MIGHT COME. THE COUNCIL AGREED THAT THE FOCUS MUST BE CONCERNS NOT DIVISIVE ISSUES; THE PROGRAM MUST OFFER A SERVICE NOT AN ARENA FOR DISPUTE.

FUTURE MEETINGS: WEDNESDAY, DECEMBER 10, 1980, AND MARCH 4, 1981, BOTH FROM 3-5 P.M. WERE SET AS FUTURE MEETINGS, WITH A POSSIBLE MAY MEETING TO BE DECIDED UPON IN THE FUTURE.

FUTURE TOPICS: MR. SCHLAGETER WILL RETURN TO THE COUNCIL MEETING TO BE HELD ON DECEMBER 10 IN ORDER TO DISCUSS WITH THE COUNCIL AND DR. MITCHELL JOINT MONITORING OF HAZARDOUS WASTE LEGISLATION IN THE SESSION TO BEGIN IN JANUARY IN COLORADO.

THE MEETING WAS ADJOURNED AT 6:00 P.M.

***Is there a doctor  
on the road or at the game?***



The Committee on Medical Aspects of Sports of Colorado Medical Society hopes to hear from physicians who share its members' interest and concern about medical coverage of running events and interscholastic athletic contests.

Please let us know if you are interested in participating in your community.

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RUNNING EVENTS:

Names of sports: \_\_\_\_\_

Please mail to:

David C. Greenberg, M.D.

Chairman

Medical Aspects of Sports Committee

Colorado Medical Society

1601 E. 19th Avenue

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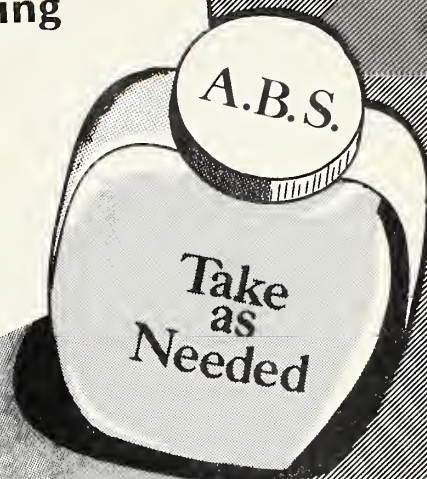
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October 7, 1980

R. G. Bowman  
Executive Vice-President  
Colorado Medical Society  
1601 E. 19th Avenue  
Denver, Colorado 80218

Dear Mr. Bowman:

It has come to our attention that a California based finance company has been conducting its loan business by means of mailings sent to Colorado residents. These mailings advertise quick cash loans for professional persons.

In one case reported to this office, a Colorado physician entered into an agreement with the California company. Although couched in the form of a sale and lease-back agreement, it is our opinion that it was a loan. The loan was used by the physician for personal purposes. The company took a mortgage on the physician's home to secure the loan. The finance charge rate on the loan was far in excess of the rate allowed under the Colorado Uniform Consumer Credit Code. Although the physician was not aware of it, in such a case, the debtor is not obligated to pay the excess charge.

Of course, not all credit transactions entered into between a Colorado resident and an out-of-state finance company will be subject to the Colorado law. Should your members receive a solicitation as described or enter into a credit transaction with a finance company, we will be happy to review the documents and advise them whether the loan is subject to and in compliance with Colorado law.

Very truly yours,

  
\_\_\_\_\_  
JAMES T. DILLON  
Deputy Administrator

JTD:ydh



## Dickinson Named To National Post

Dr. Theodore C. Dickinson, Montrose general surgeon, has been named president of the Colorado Chapter of the American College of Surgeons.

Dr. Dickinson will serve until May 1981. He is a graduate of Washington University School of Medicine in St. Louis, and interned at Vancouver General Hospital, Vancouver, B.C., and served a five-year residency in surgery at the University of Colorado School of Medicine, and a one-year residency at Malmo General Hospital, Malmo, Sweden.

## Physician Placement Services

The PHYSICIAN PLACEMENT SERVICES is a computerized placement information exchange system. The program services physicians who are seeking employment opportunities in Colorado. The mechanics of the system are simple. The computer cross-references applicant needs with employment opportunities and vice versa. If you are interested in a position or a physician please contact Colorado Medical Society, 861-1221, ext. 267.

## 105 HOSPITALS ELECT INDUSTRY LEADERS

DENVER - October 14, 1980 - The 105 hospitals in the Colorado Hospital Association have elected Jerry Happel, executive vice president, of Rose Medical Center in Denver, as 1980 Chairman of the Board of Trustees.

The election, conducted during the 56th Annual Meeting of the Colorado Hospital Association Oct. 3 in Denver, also named Tom Flickinger, administrator of Routt County Memorial Hospital in Steamboat Springs as Chairman Elect and Dale Budde, president of Mercy Medical Center, Denver, as Secretary/Treasurer.

The Colorado Hospital Association is an organization providing assistance, shared services and leadership to the entire Colorado hospital industry.

Other newly elected trustees are Al Riffel, administrator, East Morgan County Hospital, Brush; E.V. Kuhlman, president/executive director, St. Anthony Hospital Systems, Denver; Richard H. Stenner, administrator, Weld County General Hospital, Greeley; Al Farr, administrator, St. Francis Hospital, Colorado Springs and Lew Leaman, administrator, La Junta Medical Center, La Junta.

Dr. Robert Sawyer, M.D., former president of the Colorado Medical Society, was elected the physician representative and Dale Button, retired from St. Mary's hospital in Grand Junction, was awarded Trustee Emeritus honors.

Arvid B. Brekke continues his ninth year as president of the Association.

## Greek Gold Cross Awarded to Denver Doctor

Matthew H. Block, MD., professor of medicine at the University of Colorado School of Medicine, has been awarded the Gold Cross of the Hellenic Red Cross.

Dr. Block probed bone abnormalities in beta thalassemia major (BTM), a hereditary anemia which occurs in individuals, excluding Spaniards and Portuguese, who live adjacent to the Mediterranean Sea.

It is due to genetically-transmitted abnormalities that the disorder occurs. There is a failure in the synthesis of hemoglobin and a deficiency of the pigment in red blood cells which carry oxygen.

Initially blood transfusions were used but they were found to cause an iron overload in the children which in turn created problems of liver, heart, and pancreas which caused further disabilities and some instances of death.

A lately discovered drug, desferrioxamine, which combines with and extracts iron from the body's tissues, is being studied to see the specific effect on bone disabilities.

Dr. Block received both MD and PhD from the University of Chicago, and came to the University of Colorado Health Sciences Center in 1953 as professor of medicine and chief of the division of Hematology.

**Editor's Note:** It is such a pleasure to note that other journals and publications fall victim to errors in editing, proofing, printing, mailing, etc.

This notice comes from the September/October 1980 issue of the Newsletter of the Massachusetts Medical Society. We're not laughing at ... but laughing with.

### TYPOS

Typographical errors are caused by printer's devils. Most typos are letters that have been transposed or letters that have been dropped.

In the recent July/August issue of the *Newsletter* a small announcement concerning the Bicentennial coming up in 1980 had two typos. One was routine—the spelling of Bicentennial was short an “n”. The other was a beaut—the title was originally “THINK 200!” It came out as “THINK ZOO!”

It will be interesting to see what the printer's devils have to do with this little announcement.

# standards of practice

In previous issues this column has dealt with matters of child care. Adoption was discussed, as was consent to treatment by minors. The congeries of practice concerns regarding children is supplemented by three brief items: (1) physician reporting of child abuse; (2) immunization requirements; (3) infant eye care. As is true of all column items, members with specific problems should obtain advice of counsel.

## Child Abuse

Any physician or surgeon, including a physician in training, who has reasonable cause to know or suspect that a child has been subjected to abuse or neglect or who has observed the child being subjected to circumstances or conditions which would result in abuse or neglect must report that to the local department of social services or law enforcement agency.

"Child abuse or Neglect" is defined as an act or omission in one of the following categories which threatens the health or welfare of a child:

(1) Any case in which a child exhibits evidence of skin bruising, bleeding, malnutrition, failure to thrive, burns, fracture of any bone, subdural hematoma, soft tissue swelling, or death, and such condition or death is not justifiably explained, or where the degree or type of such condition or death, or circumstances indicate that such condition or death may not be the product of an accidental occurrence;

(2) Any case in which a child is subjected to sexual assault or molestation, exploitation, or prostitution;

(3) Any case in which the child's parents, legal guardians, or custodians fail to take the same actions to provide adequate food, clothing, shelter, or supervision that a prudent parent would take.

Nothing in this section refers to acts which could be construed to be a reasonable exercise of parental discipline.

## Immunization Prior To Entering School

No child is to be admitted to any school for the first time in the state of Colorado unless such child can present to the appropriate official of the school or facility certification from a licensed physician or authorized representative of the Department of Health stating that such child has received immunization against communicable diseases as specified by the Board of Health or a written authorization signed by one parent or guardian re-

questing that local health officials administer the immunizations.

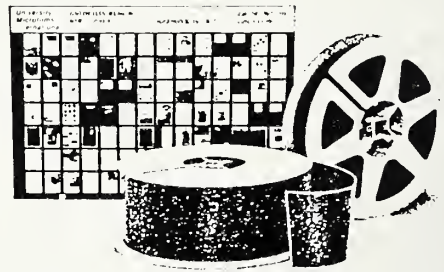
Children may be exempted from the immunization law either because the immunizations would endanger their health or because they adhere to a religious belief whose teachings are opposed to immunizations.

Current regulations specify immunization for DTP, polio, measles, rubella, and mumps.

## Care of Infants' Eyes

Any physician or other person who assists or is in charge at the birth of an infant or has care of the infant after birth has a duty to treat the infant's eyes with a prophylaxis approved by the Department of Health. The currently approved prophylaxis is Tetracycline ophthalmic ointment and Erythromycin ophthalmic ointment. The law mandates that the treatment be given as soon as practicable after the birth of the infant and always within one hour.

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**DENVER MEDICAL SOCIETY**

Amelia Chitrabamrung, M.D.  
4567 Fontana Way  
Denver, Colorado 80239

Gerald J. Ciemiega, D.O.  
1090 South Parker Road  
Denver, Colorado 80231

Steven L. Funk, D.O.  
800 South Glencoe Street  
Denver, Colorado 80222

Stanislaus O. Awariefe, M.D.  
Children's Hospital  
1056 East Nineteenth Avenue  
Denver, Colorado 80218

Steven J. Ayres, M.D.  
992 Fairfax Street  
Denver, Colorado 80220

Robert R. Brown, D.O.  
1393 South Zeno  
Aurora, Colorado 80012

Vedamurthy Reddy, M.D.  
10001 East Evans, #39-B  
Denver, Colorado 80231

John R. Russell, M.D.  
12267 East Bates Circle  
Aurora, Colorado 80014

Jon T. Peterson, M.D.  
6088 West 84th Avenue  
Arvada, Colorado 80003

Val N. Manocchio, M.D.  
7470 East Harvard Avenue, #106  
Denver, Colorado 80231

Randolph J. McCurtry, M.D.  
1100 Hudson Street  
Denver, Colorado 80220

T. Robert Mestas, M.D.  
9992 Downing Street  
Thornton, Colorado 80229

Randi J. Hagerman, M.D.  
365 Clermont Street  
Denver, Colorado 80220

John C. Harris, M.D.  
701 East Colfax Avenue  
Denver, Colorado 80203

Carol L. Lang, D.O.  
10710 West Eighth Place  
Lakewood, Colorado 80215

Thomas L. Nixt, M.D.  
1868 S. Paris Court  
Aurora, Colorado 80012

**DENVER MEDICAL SOCIETY**

Dennis L. Simpson, M.D.  
1600 Eudora Street  
Denver, Colorado 80220

Robert H. Seamon, M.D.  
Mercy Medical Center  
1619 Milwaukee Street  
Denver, Colorado 80206

Charles A. Rhodes, M.D.  
720 Ivanhoe Street  
Denver, Colorado 80220

Shobhana M. Apte, M.D.  
950 E. Harvard Avenue, #690  
Denver, Colorado 80210

Charles J. Stephans, D.O.  
4801 East Ninth Avenue, #707  
Denver, Colorado 80220

Mark S. White, D.O.  
480 Humboldt Street  
Denver, Colorado 80218

Debra Kay McKinnon, D.O.  
4701 East Ninth Avenue  
Denver, Colorado 80220

Mark S. Paller, M.D.  
4197 South Sebring Court  
Denver, Colorado 80237

Leslie A. Stanwix, D.O.  
2372 South Locust Street, #C  
Denver, Colorado 80222

William S. Magill, D.O.  
2572 South Holly Place  
Denver, Colorado 80222

Akiko Masakawa, M.D.  
1330 Gaylord Street, #1104  
Denver, Colorado 80206

Ulysses G. Mason, M.D.  
1228 Clermont Street  
Denver, Colorado 80220

Jesse D. Geren, D.O.  
6408 South Florence Way  
Englewood, Colorado 80111

David W. Hnida, D.O.  
5260 West Plymouth Drive  
Littleton, Colorado 80123

Robert Lynn Johnson, M.D.  
1721 South Krameria Way  
Denver, Colorado 80224

Donald L. McGuirk, Jr., M.D.  
8383 W. Alameda Avenue  
Lakewood, Colorado 80226

**DENVER MEDICAL SOCIETY**

Marc Feldman, M.D.  
1055 Logan Street, #1104  
Denver, Colorado 80203

L. Christopher Foley, M.D.  
1263 Elm Street  
Denver, Colorado 80220

Mary Louise Haerr, M.D.  
12076 East Hawaii Circle  
Aurora, Colorado 80012

Kenneth R. Ramach, M.D.  
4700 Homestead  
Littleton, Colorado 80123

Richard J. Taylor, M.D.  
5805 South Jamaica Way  
Englewood, Colorado 80111

Marc J. Sorkin, M.D.  
3005 East 16th Avenue, #390  
Denver, Colorado 80206

Gerald Battersby, M.D.  
701 East Colfax Avenue  
Denver, Colorado 80203

Ina Berzins, M.D.  
6030 East First Avenue  
Denver, Colorado 80220

Eugene L. Klenk, M.D.  
9450 East Mississippi Avenue  
Denver, Colorado 80231

John W. Williamson, M.D.  
1377 S. Washington Street  
Denver, Colorado 80210

Thomas R. Wolf, M.D.  
795 Poplar Street  
Denver, Colorado 80220

Chester T. Roe, III, M.D.  
Saint Luke's Hospital  
601 E. 19th Avenue  
Denver, Colorado 80203

Susan H. Westerlund, M.D.  
Presbyterian Medical Center  
1719 E. 19th Avenue  
Denver, Colorado 80218

Edward B. Whitney, M.D.  
Saint Luke's Hospital  
601 E. 19th Avenue  
Denver, Colorado

Roy A. Jared, M.D.  
2527 Albion Street  
Denver, Colorado 80207

## DENVER MEDICAL SOCIETY

Dennis A. Stump, M.D.  
Presbyterian Medical Center  
1719 E. 19th Avenue  
Denver, Colorado 80218

Pamela A. Traina, M.D.  
Presbyterian Medical Center  
1719 E. 19th Avenue  
Denver, Colorado 80218

Peter W. Valaas, M.D.  
Presbyterian Medical Center  
1719 E. 19th Avenue  
Denver, Colorado 80218

Alan F. Stage, M.D.  
6776 S. Detroit Court  
Littleton, Colorado 80122

Kaye L. Stiff, M.D.  
505 21st Street  
Golden, Colorado 80401

Douglas J. Strashley, M.D.  
3985 Chase Street  
Denver, Colorado 80212

John R. Ruddy, M.D.  
Saint Luke's Hospital  
601 E. 19th Avenue  
Denver, Colorado 80203

Dieter W. Schneider, M.D.  
Saint Luke's Hospital  
601 E. 19th Avenue  
Denver, Colorado 80203

Larry A. Sokol, M.D.  
82 Garfield Street  
Denver, Colorado 80206

Michael R. Pranzatelli, M.D.  
1039 S. Parker Road, #A-18  
Denver, Colorado 80231

Dennis C. Raphael, M.D.  
Saint Luke's Hospital  
601 E. 19th Avenue  
Denver, Colorado 80203

Leslie W. Reitman, M.D.  
790 Poplar Street  
Denver, Colorado 80220

Todd P. Nelson, M.D.  
13962 E. Stanford, #L-9  
Aurora, Colorado 80015

Charles B. Owen, M.D.  
Presbyterian Medical Center  
1719 E. 19th Avenue  
Denver, Colorado 80218

## DENVER MEDICAL SOCIETY

Joel E. Paine, M.D.  
Saint Luke's Hospital  
601 E. 19th Avenue  
Denver, Colorado 80203

Ben Muneta, M.D.  
Saint Luke's Hospital  
601 E. 19th Avenue  
Denver, Colorado 80203

Kenneth E. Najarian, M.D.  
Saint Luke's Hospital  
601 E. 19th Avenue  
Denver, Colorado 80203

George F. Nardin, M.D.  
Saint Luke's Hospital  
601 E. 19th Avenue  
Denver, Colorado 80203

Oskar Moller, M.D.  
Saint Luke's Hospital  
601 E. 19th Avenue  
Denver, Colorado 80203

Peter T. Morrow, M.D.  
Presbyterian Medical Center  
1719 E. 19th Avenue  
Denver, Colorado 80218

David M. Munch, M.D.  
940 Oneida Street  
Denver, Colorado 80220

Gilbert Al Masterson, M.D.  
Saint Luke's Hospital  
601 E. 19th Avenue  
Denver, Colorado 80203

Leigh G. McGill, M.D.  
Children's Hospital  
1056 E. 19th Avenue  
Denver, Colorado 80218

Michael Mikhail, M.D.  
Children's Hospital  
1056 E. 19th Avenue  
Denver, Colorado 80218

John A. Malmstrom, Jr., M.D.  
1490 S. Kingston Street  
Aurora, Colorado 80012

Rebecca L. Martinez, M.D.  
17139 E. Kenyon Place  
Aurora, Colorado 80012

Barry A. Legawiec, M.D.  
Saint Luke's Hospital  
601 E. 19th Avenue  
Denver, Colorado 80203

## DENVER MEDICAL SOCIETY

Aaron D. Long, M.D.  
826 Memphis Street  
Aurora, Colorado 80011

Bruce A. Lowry, M.D.  
777 Ash Street, #202  
Denver, Colorado 80220

Robert A. Knight, M.D.  
Presbyterian Medical Center  
1719 E. 19th Avenue  
Denver, Colorado 80218

Rohini Krishnan, M.D.  
Presbyterian Medical Center  
1719 E. 19th Avenue  
Denver, Colorado 80218

James R. LaManna, M.D.  
1311 Cook Street, #501  
Denver, Colorado 80206

James M. Jaskunas, M.D.  
Presbyterian Medical Center  
1719 E. 19th Avenue  
Denver, Colorado 80218

Charles H. Karaian, M.D.  
4200 E. 9th Avenue, #B-130  
Denver, Colorado 80262

Gerald Katz, M.D.  
339 Fairfax Street  
Denver, Colorado 80220

Gordon J. Gernbein, M.D.  
Presbyterian Medical Center  
1719 E. 19th Avenue  
Denver, Colorado 80218

Sharyl Hardiman, M.D.  
St. Joseph Hospital  
1835 Franklin Street  
Denver, Colorado 80218

Jeffrey E. Hawke, M.D.  
Presbyterian Medical Center  
1719 E. 19th Avenue  
Denver, Colorado 80218

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240 S. Monaco Parkway, #608  
Denver, Colorado 80224

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Saint Luke's Hospital  
601 E. 19th Avenue  
Denver, Colorado 80203

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1103 S. Monaco Parkway  
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5338 S. Havana Court  
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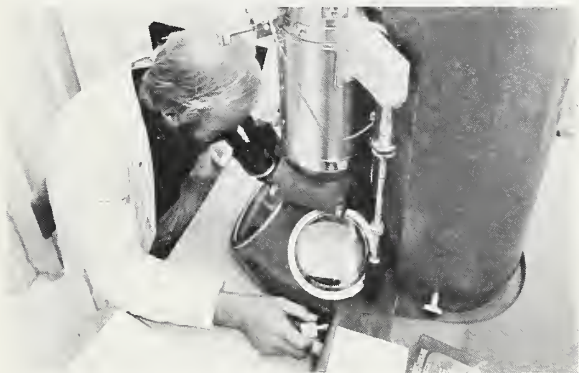
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## From Dream To Reality in Two Years: The Rocky Mountain Multiple Sclerosis Center

The Rocky Mountain Multiple Sclerosis Center was founded two years ago with the initiative, financial support and leadership of the business, scientific and medical communities. Today the Center is realizing the objective that was once only a dream: to become a unique and successful research and patient care facility designed to address the entire range of patients' MS problems while conducting extensive research aimed at discovering the cause of MS. The Center was designed as a prototype for similar MS centers the world over—centers which will forcefully confront every aspect of multiple sclerosis.

A private, non-profit corporation funded almost entirely by private sources, the Rocky Mountain MS Center is housed in the University of Colorado Health Sciences Center, with outpatient and inpatient facilities in University Hospital, and basic research laboratories located at the Veteran's Administration Hospital. In two years' time, the RMMSC staff has grown from five to 25 people, and the patient population, increasing constantly, is now close to 500. The three main divisions of RMMSC—Basic Research, Clinical Research, and Patient Care—incorporate the knowledge of numerous experts, making possible the comprehensiveness necessary for effectively challenging MS.



**Lynn Jankovsky, D.V.M., Ph.D., Assistant Professor of Pathology, is in charge of electronmicroscopy for RMMSC.**

In the Patient Care Division, for example, neurologists work with many other specialists, including urologists, ophthalmologists, psychiatrists, and physical, speech and occupational therapists to create a patient care program that challenges MS on many fronts. RMMSC's diagnostic capability, as accurate and sophisticated as any in the world today, further enhances the diversity of the patient care effort and illustrates the benefit of taking a complex approach to a complex disease.



**Occupational Therapist Beth Wolf (r) tests MS patient Monica Wheat (l) in RMMSC's Patient Care Division.**

By addressing all MS patients' needs, from diagnosis to rehabilitation, it is possible to significantly impact on a disease which once was considered untreatable.

RMMSC's Basic and Clinical Research Divisions are equally diversified. Studies are underway to investigate the human origin of a virus isolated by RMMSC suspected of playing a role in the etiology of MS. Researchers are also attempting to develop an animal model for MS. Neuropsychological studies have begun in order to study physical and psychological stress factors in MS. The Basic and Clinical Divisions are continually expanding along exciting and promising lines of inquiry.

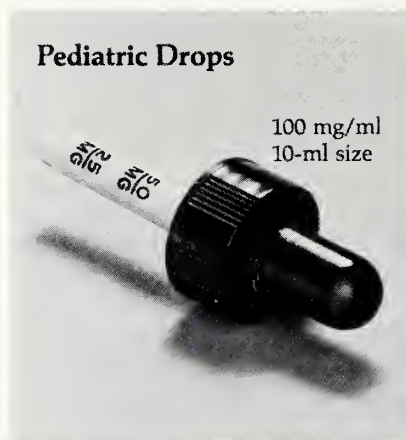
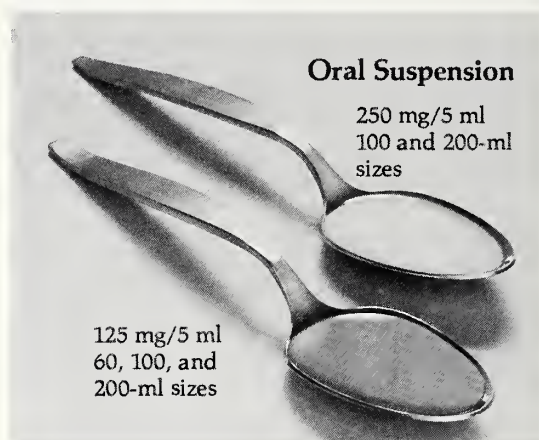
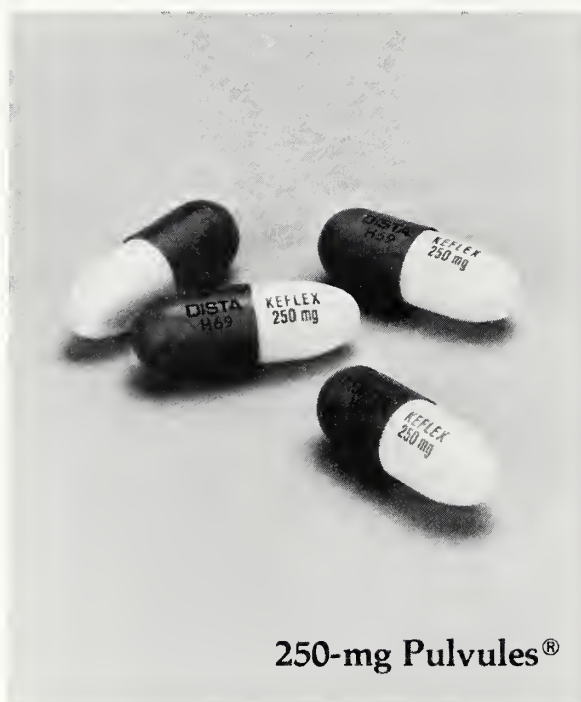
While funding is a continuing issue, and ideas for research projects and patient care needs increase faster than RMMSC can possibly keep pace with, the Center is confident that its third year of operation will be the most successful and expansive yet. It is obvious that RMMSC has identified a major need in society today, as measured by the rapidly expanding patient load, the willingness of major donors to offer financial support, and the costliness of the disease itself. The Rocky Mountain Multiple Sclerosis Center is dedicated to filling this need as completely as possible.

Genevieve Freeman  
Director of Public Relations  
RMMSC

## Kremmling Physician's Career Reviewed

Ernest Ceriani, who was making house calls in Kremmling 33 years ago, still is making them. Though Life Magazine may not be on hand, through its history-making photos by W. Eugene Smith, Dr. Ceriani's present community visits were photographed by John Sunderland of The Denver Post in an appreciation of the vicissitudes a country doctor who fulfills the ideal of that practice just as he did in 1948.

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## FDA calls for BENDECTIN patient package insert

The Food and Drug Administration said today it agrees with conclusions of an expert advisory committee that available data do not demonstrate an association between birth defect and Bendectin, a drug often prescribed to treat nausea and vomiting during pregnancy, but that it should be used only when conservative treatment fails.

The agency said it would, as the committee recommended, sponsor and monitor further research into the drug, and also propose a mandatory patient package insert that would be given to women with each new prescription.

The patient package insert would explain how the drug is to be used, its side effects and possible risks. Included will be the statement that Bendectin should be used only to treat significant nausea and vomiting that is not responsive to conservative treatment including getting more rest, drinking very hot or very cold drinks or eating dry crackers.

Patient package inserts are leaflets that are described by the pharmacist with each new prescription for a drug. They are written in language easily understandable by the patient.

FDA said the labeling that goes to physicians also would be changed to indicate that doctors should prescribe the drug only for significant nausea and vomiting not responsive to the more conservative measures.

The actions follow a comprehensive review by the agency and its Fertility and Maternal Health Drugs Advisory Committee of the scientific information about Bendectin's safety, particularly its possible association with birth defects in the offspring of women who took it during pregnancy.

The committee, after two days of hearings September 15 and 16, said existing data do not demonstrate an association between the drug and an increased risk of human birth defects. It said, however, that two studies raised "residual uncertainty" that merits further study plus warning labeling.

All the committee's recommendations are being adopted by FDA.

In a statement, Dr. J. Richard Crout, director of FDA's Bureau of Drugs, said:

"The purpose of the actions we are announcing today is to provide more and better information, to both patients and physicians, about Bendectin. This is a drug that is effective in treating nausea and vomiting during pregnancy, but it should be prescribed only when clearly needed, that is, when more conservative measures do not work."

Dr. Crout continued: "FDA will continue to support and monitor research into Bendectin. Our review of the studies to date, including some very large ones, found no association between the drug and an

increased risk of human birth defects. There is a need for additional data, however, and, as is always the case in studies of this type, it is possible to have a low level of risk that cannot be detected. That is why we advise caution in the use of all drugs in pregnancy. We agree with the committee, however, that the ongoing epidemiology studies should continue to be monitored and that additional studies of the drug's effectiveness in controlling nausea and vomiting unresponsive to conservative measures be performed."

Dr. Crout added: "One message that we want pregnant women and physicians to understand is that no drug should be taken during pregnancy unless it is essential."

FDA has met with the manufacturer of the drug, Merrell-National, to discuss the changes in physician labeling. The agency already is drafting the proposed patient package insert, which would be published with an opportunity for public comment. The drug manufacturer would be required to provide the inserts to pharmacists to distribute to patients with each new Bendectin prescription.

Three studies are continuing into Bendectin and birth defects. They are being done by Dr. Allen Mitchell of the Boston University Medical Center, Dr. Hershel Jick of the Boston Collaborative Drug Surveillance Program, and Dr. Jose Cordero of the Center for Disease Control, Atlanta.

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### Foundation Report

Continued from page 380

- Obstetrics/Newborn Services starts 6/11/82
- Pediatrics Services

The Foundation has already been approached by the State Health Planning and Development Agency to appoint physicians to the Technical Advisory Committees charged with the development of guidelines for appropriateness review for CT Scan, Cardiac Catheterization and Open Heart Surgery and Radiation Therapy. In addition, at its September 23 meeting, the Foundation Board of Directors passed a resolution directing that the Foundation take a more active role in the quality assessment portion of appropriateness review and further directed that the Foundation's current Memoranda of Agreement with each of the HSAs (required by regulation for the PSRO) be renegotiated relative to such a role. The decision of the Foundation Board was predicated on the belief that quality assessment is a professional responsibility and should be performed by a peer review organization with professional resources and experience in quality assurance.

All segments of organized medicine will be kept up to date on an ongoing basis by the Foundation with respect to HSA and state planning activities. If you desire further information on the Foundation's activities in the health planning area, please contact the Division of Program Planning and Evaluation at the Foundation, 861-1221, extension 225.

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### CHRONIC PAIN

#### FURTHER OBSERVATIONS FROM CITY OF HOPE NATIONAL MEDICAL CENTER

EDITED BY: Benjamin L. Crue, Jr., MD,  
SP Medical & Scientific Books, Jamaica, N.Y.  
\$45.00

This book is a collection of papers by many authors, most of whom are associated with the City of Hope National Medical Center, in Andurate, California. Dr. Crue is apparently the founder and head of this clinic. This book represents one in a series of monographs from this institution.

There are several sections including, a long and detailed section on Neurophysiology, a section on Neurosurgery and cancer pain, a section on the psychological aspects of chronic benign pain and various other chapters. It is difficult to find a consistent thread from section to section and chapter to chapter except that there is an underlying feeling that psychotherapy is the best method over all for treatment of chronic benign pain. The authors separate their pain unit into the cancer pain and the chronic benign pain and, of course, the treatment varies for the two types of problems. I was particularly impressed by the chapters having to do with the management of the dying patient and also with the use of analgesics in chronic pain.

One has the feeling that this is an attempt by this pain unit to promote their form of treatment, which is certainly a reasonable goal. However, the statistical results are not terribly impressive and certainly would not lead this author to refer a number of patients to that particular Center. A number of other Centers are in existence across the country that deal with pain problems and it does not appear that this unit has any particular unique forms of treatment.

I found this book very difficult to read. It is long and disconnected and the followup data is rather unimpressive in my opinion. All in all the book has very little to recommend to the average practitioner.

Jack A. Klapper, MD  
Denver, Colorado



# The diagnosis and treatment of acute maxillary sinusitis\*

Paul M. Redstone, MD, Denver, Colorado, LaVonne Bergstrom, MD, Los Angeles, California, and Peter E. Dans, MD, Baltimore, Maryland

*Although much has been written about acute sinusitis, review of the literature reveals disagreement about criteria for its diagnosis, the most appropriate therapy, and the best measures of response to treatment.<sup>1-6</sup> Previous studies have described symptoms and signs in patients with sinusitis, but there is little information on their specificity. Since sinus disease is a common problem in outpatient medical practice, we instituted this study to clarify some of the diagnostic and therapeutic problems encountered in managing patients with suspected sinusitis.*

## Methods

The study was performed in the Adult Walk-In Clinic of the Colorado General Hospital, which serves a broad socioeconomic population of metropolitan Denver. The clinic has a daily census of 60 to 80 patients and is staffed by three to four nurse practitioners, a first-year resident, and an attending physician. Patients were initially selected for the study on the basis of one or more of the following criteria:

1. Tenderness to palpation over the maxillary or frontal sinuses.
2. Positive transillumination, that is, if when the transilluminator was placed over the antrum just under the orbital ridge light transmission through the maxillary sinus was absent or decreased as compared to a group of normals.
3. Purulent rhinorrhea and nasal congestion for over three days.
4. Periorbital edema.

Additional criteria that had to be met were: 1) age (18 or over), 2) women not pregnant, 3) no antibiotics for one week prior to onset of symptoms and 4) agreement to return in 10 days for reevaluation. Informed consent was obtained from all patients after the nature of the study was explained to them, including the studies to be performed and the possible side effects of treatment.

Standardized subjective and objective information was obtained: age; sex; history of fever, chills, rhinorrhea, nosebleed, congestion, postnasal drip, sinus pain, pain in jaw or teeth, headache, sore throat,

hoarseness, periorbital swelling and present medication; past history of previous sinusitis, allergies, asthma, bronchitis, heart disease, lung disease, hypertension, diabetes and smoking; *physical exam* of nose, ears, pharynx and neck specifically noting presence or absence of sinus tenderness, periorbital edema, and sinus transillumination. Laboratory exam included sinus x-ray, CBC and differential, ESR, cold agglutinins, and bacterial and viral cultures. Bacterial and viral cultures were taken from the middle meatus. Anaerobic cultures were not done since direct sinus aspirates were not performed. An abnormal sinus x-ray was used as the absolute criterion for the diagnosis of sinusitis.<sup>1-3</sup> Sinus x-rays were taken in the occipitofrontal, occipitomeatal, lateral and axial views and were initially read by a radiologist or clinic physician and subsequently reviewed by a single otolaryngologist (LB). Patients were divided into three groups. Patients with abnormal x-rays, (mucosal thickening 6-8 mm, fluid level, or opacification) were considered to have acute sinusitis and given pseudoephedrine 60 mg po q.i.d. plus either ampicillin 250 mg po q.i.d. (even hospital number) or doxycycline 200 mg stat plus 100 mg q.d. Patients with normal x-ray or mucosal thickening 6 mm (control group) were given pseudoephedrine 60 mg po q.i.d. Treatment was continued for 10 days and patients were asked to return at that time. The following criteria were used to assess improvement:

## Results

Two hundred thirty patients entered the study and 133 completed it (101 in the treatment group and 32 controls). Thirty were deleted because they were begun on the wrong treatment regimen or review of x-ray showed an incorrect initial reading. The rest failed to return. Initial data on the patients lost or deleted are included in the analysis of symptoms and signs. The demographic data for the three treatment groups were quite similar except for the male preponderance in the doxycycline group (Table I). All sinusitis patients in the study had maxillary sinus disease and a few had one or more additional sinuses affected. The presenting symptoms and physical findings are depicted in Table II. There was no clear

TABLE I  
Treatment Groups

	Doxycycline (43)	Ampicillin (58)	Control (32)
Median Age	28	27	24-1/2
Sex			
Male	24	19	10
Female	19	39	22
History of Previous Sinusitis	14	19	10
Median Duration of Symptoms (Days)	7	7	7
Median Days to Revisit (Days)	11	11	11

difference between the groups, although the presence of exudate on physical examination was more common in the sinusitis group ( $p 0.05$ ). Bacterial cultures largely grew "nonpathogens" (Staphylococcus epidermidis, diphtheroids, Neisseria and alpha streptococcus) Figure 1'. Only the presence of the pneumococcus seemed to be more frequent in patients with sinusitis ( $p .01$ ).

Viruses were isolated from 12 patients, but were no more frequent in the sinusitis group than the control. Rhinovirus was isolated from 3 (2%) sinusitis patients and 1 (1.6%) control; influenza A from 2 (1.4%) sinusitis patients and 1 (1.6%) control; influenza B from 3 (2%) sinusitis patients and 1 (1.5%) control; and Adenovirus from 1 (0.7%) sinusitis patient and no control.

Sinusitis was more common in the winter and spring months as were the non-specific viral illness in the control group.

### Treatment

The results of treatment are shown in Figures 2 and 3. Seventy-five per cent recovered or improved in the ampicillin and doxycycline groups. Patients with persistent fluid or opacity were referred to the Otolaryngology Clinic and underwent sinus irrigation.

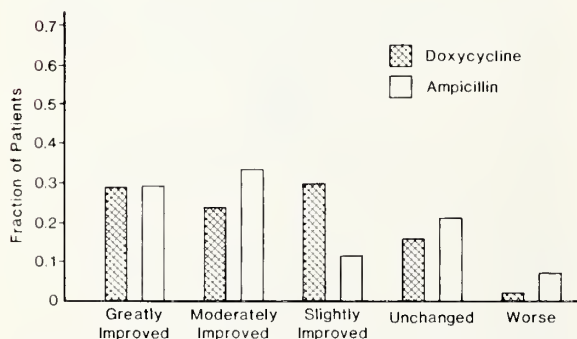


Fig. 1. Bacterial Culture Results (taken from region of maxillary sinus ostium).

### Side Effects

Side effects were fairly common in all groups, but were seldom severe; 32% of the doxycycline group, 23% of the ampicillin group and 12% of controls. Four patients had to be dropped because of medication side effects, three in the ampicillin group (two with diarrhea, one with nausea and vomiting) and one in the doxycycline group (nausea, vomiting).

### Discussion

Problems still occur in the diagnosis and treatment of acute sinusitis. Although many diagnostic criteria are described in the literature, the general consensus seems to be that x-ray, with or without sinus aspiration, is the most sensitive technic for diagnosing acute maxillary sinusitis.<sup>1,8</sup> The presence of an airfluid level and mucosal thickening greater than 6-8 mm, are the best x-ray correlates for acute disease, although comparable mucosal thickening is sometimes seen as a chronic change. An abnormal x-ray can occur in 25 per cent of asymptomatic adults, but most only have minimal mucosal thickening.<sup>9</sup> A single occipitomental view of the maxillary sinuses has recently been shown to be quite specific for sinus disease<sup>8</sup>, and may be useful as a screening exam. Although more difficult to perform routinely, aspiration of purulent secretion is the best confirmation of acute disease. Approximately 6 per cent radiographically normal sinuses (patients with symptoms) disclose purulent secretions on aspiration.

What seemed most striking from our data is that some of the traditional symptoms and signs associated with sinusitis (congestion, sinus aching, purulent exudate, sinus tenderness . . .) are as common in those patients without sinusitis as those with radiographic disease. This is similar to the findings recently reported by Axelsson and Runze.<sup>10</sup> These findings make the diagnosis of sinusitis by history and physical exam hazardous. Antibiotics are not needed for routine upper respiratory infections. The use of sinus x-rays or aspirations where practical, would lead to a

Continued on page 413



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more rational basis for treatment.

Transillumination has been shown to be helpful in some studies but not in others.<sup>7,11</sup> As illustrated by Evans *et al.* the problem appears to be combining the "opaque" and "dull" groups. In their study, 14 of 15 sinuses with normal transillumination and 19 of 26 that were dull (decreased light transmission) had normal aspirates, whereas 24 of 24 that were totally opaque had abnormal aspirates.<sup>7</sup> However, as performed in our clinic, by many, relatively inexperienced people, transillumination did not give any consistent result.

The microbiologic findings in acute sinusitis have varied in several studies due to sampling technique.<sup>4,7,12</sup> There has been little correlation between cultures obtained from the nasal antrum, even if taken at the opening in the middle meatus as was done, and direct aspirates of the sinus. In those studies where direct aspirates were performed, pneumococcus was the most frequent pathogen with a mean of about 31 per cent in most studies followed by *Hemophilus influenzae* with a mean of 21 per cent. Anaerobes were isolated in 6%, *S. aureus* in 4%, and 23% were sterile. Evans has shown that there is a strong correlation between the high aspirate leucocyte count (greater than 1,000/cu mm) and infection as manifested by bacterial titers of 10<sup>5</sup>/ml, or isolation of a virus or fungus.<sup>7</sup>

Viruses have been thought to play an initiating etiologic role in development of acute sinusitis, but only two reports have isolated viruses, either adenovirus or rhinovirus, from sinus aspirates.<sup>7,13</sup> The role of fungi, especially penicillium mold, is controversial,

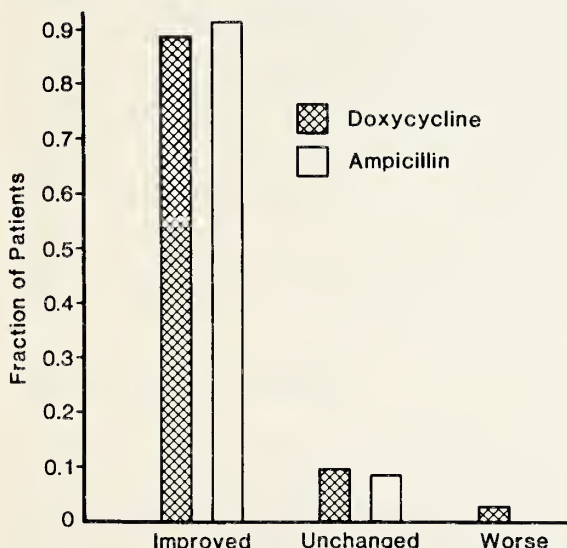


Fig. 2. Results of Antibiotic Treatment Evaluated by Symptoms. Doxycycline - 43 patients. Ampicillin - 58 patients.

TABLE II  
Presenting Symptoms and Signs (%)

	Sinusitis (145) Patients	Control (62) Patients
Symptoms:		
Pain	89	84
Congestion	88	84
Rhinorrhea		
Clear	14	18
Purulent	80	77
Sore Throat	59	69
Post Nasal Drip	50	50
Hoarseness	28	39
Cough	25	19
Fever	19	19
Nosebleed	18	18
Periorbital Swelling	11	11
Signs:		
Positive Transillumination	78	71
Sinus Tenderness	60	56
Temperature		
>37-38	17	23
>38	2	0
Exudate		
Clear	8	2
Purulent	13	8
Periorbital	3	3

although Evans found this organism in one patient in his study and it has been isolated in two others subsequent to termination of that study.<sup>7</sup>

Various treatment regimens and antibiotics have been recommended.<sup>4,6,14</sup> Only one recent study was controlled, in the sense it had one group of sinusitis patients treated with decongestant alone.<sup>5</sup> The majority of patients treated only with decongestant improved although not as rapidly as those treated with antibiotics and/or irrigation. Effectiveness of antibiotic treatment should be related to the antimicrobial sensitivity of the organism(s), to the antibiotic chosen, and the antibiotic's ability to get to the site of infection. The most common etiologic organisms (pneumococcus and *Hemophilus*) are usually susceptible to ampicillin and doxycycline. On the basis of *in vitro* sensitivity testing, ampicillin should be more effective. However, tetracyclines appear to get into sinus secretions better than the penicillins, although there is controversy in the literature about this.<sup>15,16</sup> In this study there was no consistent difference in the effect of doxycycline and ampicillin on the recovery from sinusitis.

In summary, maxillary sinusitis is a common disease that is difficult to diagnose by symptoms and signs alone. An x-ray or sinus aspirate is necessary to confirm the diagnosis. Although, no truly controlled study of antibiotic effectiveness in sinusitis has been done, it seems prudent to begin treatment with a decongestant plus a broad spectrum antibiotic. Sinus irrigation is usually reserved for patients who fail to respond to the initial therapy. ●

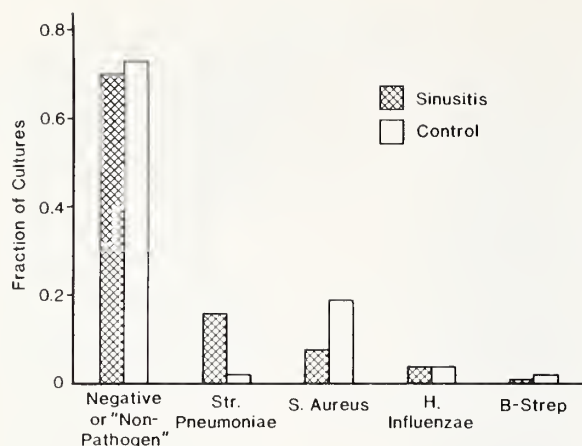


Fig. 3. Results of Antibiotic Treatment Evaluated by X-ray, Doxycycline - 43 patients. Ampicillin - 58 patients.

\*The article comes from the Department of Medicine and Otolaryngology, University of Colorado Health Sciences Center, Denver. At the present Dr. Bergstrom is at the UCLA Center for the Health Sciences, Los Angeles, California, and Dr. Dans is at the Johns Hopkins University School of Medicine, Baltimore, Maryland. Grant support was from Pfizer Pharmaceutical Company. For reprints, write: Paul Redstone, MD, University of Colorado Health Sciences Center, Box B213, 4200 East 9th Avenue, Denver, Colorado 80263.

#### ACKNOWLEDGEMENT

The authors thank Nancy Aitable of the Department of Biometrics for statistical assistance; the nurse practitioners of the Adult Walk-In Clinic, Colorado General Hospital for their cooperation in referring patients for study; and LaJuanda Smallwood and Gail Pfenninger for technical help in preparing the manuscript.

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# Temporary transvenous cardiac pacing

Carl E. Bartecchi, MD, Pueblo, Colorado\*

*Two hundred and fifty consecutive patients requiring temporary pacing for a variety of cardiac disorders were treated with a single pacemaker catheter electrode placement procedure utilizing the subclavian vein approach. The outlined procedure is both rapid and effective, and particularly suited to the community hospital setting. Stable pacing was achieved in a high percentage of patients with few complications.*

## Introduction

The sudden absence of cardiac contractile activity, reversed by electrical currents directed at the heart is a concept recognized as early as the eighteenth century.<sup>1</sup> Early crude and questionably effective efforts were followed in this century by effective external electrical stimulation, and in recent years by simple, dependable endocardial pacing techniques.

Temporary transvenous endocardial pacing has become a widely accepted procedure useful in an increasing variety of clinical situations. The popularity of temporary pacing procedures is due in part to the fact that they can be performed rapidly, at the bedside, with inexpensive equipment, generally available in the average community hospital. The pacemaker catheter electrode can be placed by any of a variety of methods. The following is a report of my experience with a single pacemaker catheter placement procedure using the subclavian vein and a small diameter semi-floating pacemaker catheter in two hundred and fifty consecutive patients requiring temporary pacing.

## Material and Methods

Between 1972 and 1980, 250 consecutive patients, ranging in age from 15 to 94 years old (Table I) required the insertion of 254 temporary endocardial pacing catheters. All procedures were performed at the bedside in one or the other of Pueblo's two community hospitals. The majority

of these procedures were performed in the coronary care units, though the emergency room, patient wards, and x-ray department were frequently used.

All procedures were performed following a well-outlined format.<sup>2,3</sup> Important elements of this procedure included the use of a small diameter (French 4), bipolar, semi-floating, pacing catheter (usually of the Cordis® variety) passed through a teflon sheath adequately placed, percutaneously, into the subclavian vein. Catheter positioning was done solely by EKG guidance and manipulated until the most satisfactory position was achieved. The latter required the recording of a current of injury from the catheter tip, consistent ventricular pacing at a threshold of .5 mamp, and assurance of adequate sensing of a demand pacemaker with no detectable evidence of competition. The site of right ventricular stimulation was further delineated by the surface electrocardiogram pattern of the pacemaker-induced complex - left bundle branch block with left axis deviation (achieved in 74 per cent of cases) being the desired pattern. Other right ventricular locations were on occasion accepted depending on the clinical urgency of the pacing requirement. Special attention was directed to the point of penetration of the skin by the teflon sheath. Local antibiotics were utilized in each case. Systemic antibiotics were not used. The catheter was anchored in place with tape. Dressings were changed at least every 72 hours.

Repositioning of displaced catheter electrodes was accomplished in several cases by thoroughly cleansing the catheter and the surrounding skin area with povidone-iodine solution prior to manipulation of the catheter, and once again establishing a sterile field in which to work.

The pacemaker utilized was a QRS-inhibited external pulse generator (Medtronic 5880A or earlier model), secured to the chest or arm of the ambulatory patient.

Most procedures were performed in less than 15 minutes, though a few required more than 20 minutes and rarely as much time as two to three hours.

## Results

A variety of clinical situations called for a temporary pacing modality (Table II). Thirty-six patients experiencing cardiac arrest (Cor Zero) were considered candidates for temporary pacing. In these patients, the procedure was performed during cardio-pulmonary resuscitation efforts or shortly afterwards, and initiated because of some EKG evidence of return of ventricular activity at inadequate or ineffective rates. It was often difficult or impossible to determine the adequacy of catheter placement in many of these patients. The poor survival in this group reflects the catastrophic nature of the event that precipitated the arrest as well as complications noted before, during or after the event which when retrospectively reviewed or pathologically evaluated, frequently suggested little chance for survival.

One hundred and twenty-three patients required temporary pacing in the setting of an acute myocardial infarction. The predominant location of the infarction and the high incidence of complete heart block is pointed out in Table III. Those patients without complete heart block usually demonstrated some form of high grade (advanced) A-V block. Patients with inferior wall myocardial infarction associated with complete heart block were considered candidates for pacing when the heart rate slowed to 45 or below, was unresponsive or responded adversely to Atropine, was accompanied by ventricular irritability, or when the medical record or old EKG suggested a previous myocardial infarction. A recent study by Tans *et al.*<sup>4</sup> showed that high degree A-V block in the setting of acute inferior myocardial infarction was associated with more extensive myocardial damage and higher mortality rate as compared to those without A-V block. It also showed that patients with power failure at the time of appearance of high A-V block and a ventricular rate of less than 50 per minute seemed to profit from pacemaker therapy.

Patients in the acute myocardial infarction group often had other problems such as cardiogenic shock, congestive heart failure, and ventricular arrhythmias requiring potentially dangerous antiarrhythmic agents. In these patients, pacing often proved useful in treating congestive failure patterns as well as improving blood pressure and renal function, and occasionally in the treatment of resistant ventricular arrhythmias by over-drive pacing. Seventy-two patients in this group were alive at least one month after leaving the hospital.

TABLE I

Age and Sex of Study Patients

Age	Male	Female
10-20	0	1
21-30	2	0
31-40	3	0
41-50	13	5
51-60	36	5
61-70	51	26
71-80	42	35
81-90	15	13
91-99	2	1
Total	164	86

Sixty patients with the *sick sinus syndrome* required temporary pacing. This small but special segment of our total *sick sinus syndrome* population had certain characteristics which called for initial therapy with temporary pacing. Eight patients had acute myocardial infarctions which were complicated (congestive heart failure, hypotension, etc.) by either brady or tachyarrhythmias related to that syndrome. Permanent pacemakers were not required in that group. In the fifty-two remaining patients, recent single or recurrent Adams-Stokes episodes in twenty patients, congestive heart failure, hypotension, etc. in others, and the possibility of drug toxicity, a transient ischemic process, or the need for further evaluation of the patient, called for temporary pacing rather than permanent pacing as the initial modality. Permanent pacing was eventually required in thirty-three of the latter patients.

Sixteen patients, 66 to 93 years of age, all but one with previous infarctions, angina or other evidence of coronary artery disease, presented with symptoms related to the development of complete heart block (12 patients) or other forms of high grade A-V block (4 patients). Adams-Stokes episodes occurred in ten patients and permanent pacemakers were eventually required in seven patients.

Four patients evaluated prior to major surgical procedures requiring general anesthesia were found to have complete heart block or patterns suggestive of the *sick sinus syndrome* with slow, symptomatic heart rates. Temporary pacing was utilized in order to allow the surgery procedure to be performed safely. All patients did well with no complications, two patients receiving permanent pacemakers prior to discharge from the hospital. Eleven patients required pacing for a variety of



TABLE II  
CLINICAL SITUATIONS REQUIRING TEMPORARY PACING

<u>PROBLEM</u>	<u>PATIENTS</u>	<u>PATIENTS RESPONDING TO PACING EFFORTS</u>	<u>SURVIVORS*</u>
1. CARDIAC ARREST	36	25	3
2. ACUTE MYOCARDIAL INFARCTION	123	119	72
3. SICK SINUS SYNDROME	60	60	50
4. CORONARY ARTERY DISEASE WITH ADVANCED A-V HEART BLOCK	16	16	9
5. PRE-OPERATIVE PACING REQUIREMENT	4	4	4
6. OTHER	11	9	7
<b>TOTAL</b>	<b>250</b>	<b>233</b>	<b>143</b>

\* Alive one month post hospital discharge

major medical problems often accompanied by severe underlying cardiac disease. In four patients the cardiac disease was complicated by the presence of severe Digitalis and/or Quinidine toxicity. One patient developed severe bradycardia in the setting of a massive salicylate and acetaminophen overdose. Another patient, poisoned with arsenic, developed a complete heart block followed by a cardiac arrest. A cardiomyopathy, and a connective tissue like disorder in a 47 year old male were ultimately responsible for cardiac rhythms and symptoms which called for temporary pacing and eventually a permanent pacemaker in the latter case. Adams-Stokes episodes necessitated temporary pacing therapy in five patients. Central nervous system complications were common in this particular group.

In the two hundred and eight non-cardiac arrest patients responding to pacing efforts, pacing electrodes were used for eight hundred and fifty-seven days for an average of 4.1 days per patient. Temporary pacing catheters were left in place for periods of less than one hour to as long as 15 days.

Autopsies confirming the location and degree of myocardial involvement as well as adequacy of pacing catheter placement in some cases, were obtained in 55 of the 107 patients that expired.

## Complications

Complications related to the temporary pacemaker procedure or the period of pacing were relatively few. The subclavian vein was cannulated in all but 2 patients, one of the latter being in the

setting of a cardiac arrest. A single patient developed a small uncomplicated pneumothorax. In five patients, the pacing electrode could not be directed into the right ventricle, or would not remain lodged in that chamber. In one patient, a massive embolic phenomenon explained the obstruction, and in two others, venous anomalies were demonstrated. In two patients, the lack of ability to achieve pacing rapidly no doubt contributed to the deterioration of the patients' course. Twenty-two patients demonstrated transient premature ventricular contractions at the time of electrode insertion, one patient developing ventricular tachycardia which was easily controlled with a bolus of Lidocaine. One patient had a run of supraventricular tachycardia during electrode placement. In twenty-five patients, effective pacing was lost within a two-day period. A few patients required only the increase of the voltage output of the pacemaker, the others required catheter repositioning, or in a few cases, catheter replacement. In two cases, the loss of effective pacing contributed to the clinical deterioration of the patient. Late electrode displacement, just prior to catheter removal, and requiring no repositioning, occurred in four patients without consequence.

Prior to pacemaker catheter placement, fever was present in nine patients, and due to multiple etiologies. No new temperature elevations were noted while the pacing catheters were in place. Other complications reported with temporary pacing procedures, such as phlebitis, hematomas, myocardial perforation, and bacteremia, were not present in this series.

TABLE III  
ACUTE MYOCARDIAL INFARCTION PATIENTS  
REQUIRING TEMPORARY PACING

PATIENTS	PREDOMINANT LOCATION OF THE INFARCTION	PATIENTS DEMONSTRATING COMPLETE (THIRD-DEGREE) A - V BLOCK	REQUIRED PERMANENT PACING	SURVIVORS
77	ANTERIOR	40	7	35
28	INFERIOR	22	4	25
12	POSTERIOR	10	0	6
6	SUBENDOCARDIAL	4	0	6
TOTAL	123	76	11	72

## Discussion

Two hundred and fifty consecutive patients requiring temporary pacing for a variety of advanced cardiac lesions, as suggested by the presence of one hundred and eleven patients with complete heart block and sixty-two patients with Adams-Stokes episodes, were treated with a single pacemaker catheter placement procedure, utilizing the subclavian route. The subclavian approach has proven to be safe, as well as rapid and effective. A recent study<sup>5</sup> points out its particular effectiveness in the very elderly patient in spite of previous disfavor<sup>6</sup> with the subclavian route in that group. Other access routes, including the brachial, femoral, external, and internal jugular veins have all proved effective in the hands of particular individuals skilled in their cannulation, but in general would appear to be associated with higher incidences of electrode displacement, limitations of the patients ambulation, or upper extremity activity, or more frequent or significant complications. The subclavian approach, while rapid and effective, is not without complications even in experienced hands, and should not be used by those uncertain of the technic, unfamiliar with the anatomy, or unaware of the potential complications and their treatment.

The benefit of temporary pacing would appear obvious in many of the situations already described. There has been some controversy, however, as to the ability of prophylactic temporary pacing to improve hospital survival in patients with conduction blocks complicating acute myocardial infarction. But, there have been reports of patients experiencing sudden death from third degree A-V block in the absence of cardiogenic shock. At least four survivors among six patients in this series of acute myocardial infarctions with complete heart block had prolonged periods of total asystole during which they were completely dependent on pacemaker stimulation.

The frequency of the *sick sinus syndrome* has recently been reviewed.<sup>7</sup> The need to withhold permanent pacing until the data on a patient is clear-cut has been emphasized. Temporary pacing appears to be a reasonable alternative during the evaluation period, especially if the patient is symptomatic or a possibility exists that the condition is transient or one unmasked by drugs.

The presence of a temporary pacemaker in many of the conditions described certainly adds to the safety and flexibility in the use of antiarrhythmic drugs which may be required, especially in the setting of an acute myocardial infarction. Temporary pacing efforts, in many of the situations described, had the ultimate effect of sparing the patient an unnecessary and expensive permanent pacemaker. ●

- <sup>1</sup> Bartecchi, C.E.: Cardiopulmonary resuscitation - an element of sophistication in the eighteenth century. *Amer H Jml*, 100: 580-581, 1980.
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- <sup>6</sup> Daily, P.O., Griep, R.B., Shumway, N.E.: Percutaneous internal jugular vein cannulation. *Arch of Surg* 101: 534-536, 1970.
- <sup>7</sup> Ferrer, I.M.: The primary pacemaker. *Chest* 75: 376-379, 1979.



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### THE COVER

Our cover this month looks toward a blend of the old and the new, particularly as they effect the practice of medicine. The issues which confront the physicians are many, including the new Federal Government Administration in major proportions. COLORADO MEDICINE in 1981 is pledged to bring you information which will service your needs in achieving the amalgam. News features and contributions in this issue reflect some of the matters which must be dealt with in the coming year.

Address all correspondence relating to subscriptions, advertising or address changes, manuscripts, organizations and other news items relating to editorial content to Editorial and Business Office.

Editorial and Business Office  
1601 E. 19th Ave.  
Denver, Colorado 80218  
Telephone (303) 861-1221

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*Colorado Medicine* (ISSN-0199-7343) is published monthly for \$12 per year by the Colorado Medical Society, 1601 East 19th Avenue, Denver, Colorado 80218. Second-class postage paid at Denver, Colorado. POSTMASTER: Send address changes to *Colorado Medicine*, 1601 East 19th Avenue, Denver, Colorado 80218.

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# president's letter

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It seems an appropriate time to comment from the Chair on how both the Presidential and Senatorial election results will directly effect Colorado's health programs in the next four years.

A striking difference between the health policies promoted by President Carter and those endorsed by President-elect Reagan will undoubtedly have a substantial impact on the medical society. Unlike President Carter, Reagan is opposed to regulating the amount of money hospitals may charge for services. He is adamantly against passage of a national insurance plan and considers such a measure to be 'socialized medicine,' which he describes as the 'antithesis of quality medical care.' The former California Governor plans to trim health-care bureaucracy and costs by first controlling the source of the problem: inflation.

Implemented for consultation on these issues is 'The Health Transition Team,' composed of people who are, largely, demonstrated friends of medicine. The professionals will have a great impact upon the



direction of health-care policies in the upcoming term. Kenneth Platt, M.D., former CMS president who has served as health advisor to the administration of three presidents, said, "The health policies Reagan recommends are what every administration should have done." Dr. Platt is in daily contact with the Reagan Transition Team in Washington and will spend Thanksgiving week in the nation's capital directly addressing several important issues.

As a result of the elections, the U.S. Senate will shift from Democratic to Republican majority and alter from a liberal to a much more conservative posture. Accompanying it are similar but less impressive changes in the House. Ronald E. Tegtmeier, M.D., member of the CMS Public Information Committee, said "Reagan wants to encourage people to become self-sufficient, instead of the impersonal federal government doing everything, there will be more of a personal level—with the encouragement of government, but not with the government doing it all." Representative Tim Wirth expressed his concern about what he considers to be the most crucial issue facing the Denver Metro area: How Denver will finance its health and hospitals.

I think we should anticipate being asked to 'put-up or shut-up' on the issue of keeping costs contained. If the emphasis of cost containment shifts from federal to state, many things become incumbent upon providers and their organizations. These include: making quality decisions regarding health-care delivery issues and attendant need for increased local review activities (which are generated by doctors and promulgated by provider organizations).

## ***Beware the Drug Addict!***

Doctors are advised that a cry for Dilaudid may reveal a drug addict, playing on their good will. In common incidents, these individuals describe themselves as being "from out of town," and their complaints are of kidney pain, migraine headache, or pre-operational stress. In the doctor's office he will try to steal prescription order forms which include both doctor's name and DEA number. A prescription written for such an individual will enable him to acquire drugs illicitly.

Pinpointed pupils, a drowsy and apathetic attitude, and "tracks" on wrists or inner arms make identification of addicted persons possible. In checking blood pressures, these "tracks" can easily be seen.

—Colorado Department of Public Safety

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Limon, Colorado 80828

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1612 6th Street  
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181 West Meadow Drive  
Vail, Colorado 81657

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## For The One Man In 100



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## Reapportionment in 1981

(excerpted in part from an article in *American Demographics* and the book *Colorado* by Roger Walton)

The 1981 apportionment of congressional seats among the states will signal one of the most dramatic shifts of political power in our country's history. The 1981 apportionment *within* each state of both the congressional and state legislative districts will shape national, state, and local politics until 1991.

When the "Fourth Count" data from the U.S. Bureau of Census is received in April, 1981, the states will begin drawing new lines for their congressional and legislative districts. How the lines are drawn, whether to the electoral advantage of Republicans or Democrats, may well determine the composition of the U.S. House of Representatives and of the state legislatures for years ahead.

Rather than dividing the total U.S. population by 435, a statutory formula, "The Method of Equal Proportions", is used to apportion congressional seats among the states. Under the U.S. Constitution, each state is guaranteed one representative in the House of Representatives: thus, the first 50 seats are automatically allocated, one per state. Each of the remaining 385 seats is then allotted a "priority number" derived by the Bureau of the Census by multiplying the state's population by the formula  $1 \div N(n-1)$  where "n" is each extra district by state. The priority numbers are then ranked and the extra districts assigned until none remains.

Some of the winners and losers in this mathematical exercise are already known. Based on current estimates, Florida and Texas will each gain two congressional districts; Arizona, California, Oregon, Tennessee and Utah will gain one. In turn, however, an equal number of seats must be extracted painfully from other states. The expectation is that New York will lose three, Ohio two, and Illinois, Michigan, Pennsylvania and perhaps South Dakota one apiece. Few questions will stir more controversy among incumbents in these states than this: whose seats will be abolished?

In terms of our new regional jargon, the losers in congressional reapportionment are clearly the "Frost-belt" states, the winners the "Sun-belt" states. Nationally it is the heavily urban and center-city areas that are losing population. Even in states that are gaining seats, losses are being recorded in the large metropolitan areas.

(Continued on page 436)

## Possible Legislative Issues 1981

The Colorado Legislature will convene on Wednesday, January 7 and this session all the efforts of your Government Affairs Division staff will focus on monitoring and lobbying health related issues.

Issues which will in all probability be introduced during the 1981 legislative session are listed below. The Council on Legislation urges you to comment on the issues that are of particular interest to you and your society. The CMS legislative effort will be most effective if each of you becomes involved and speaks out **NOW**. Questions concerning any of the items may be addressed to the Government Affairs Division, at 861-1221, EXT. 266, or WATS 1-800-332-4150).

### 1 & 2—Medical Indigency

A simplified version and combination of two medically indigent bills introduced in this year's session. The bill has three parts: statutory recognition of the medically indigent, a group health insurance pilot program for Colorado's uninsured population, and a catastrophic health expense limitation plan.

### 3—Commitment Laws - Violent Patients

An interim study committee has about decided not to change commitment laws, but there is discussion of a required followup period on released patients (similar to parole).

### 4—Funding and Administration of the Community Mental Health Program

This may well boil down to an argument between Denver and the rest of the state. Changes may be suggested creating a new type of central administrative authority and/or a return to funding based on the number of patients served instead of on the geographic size of the area served by a center.

### 5—Motorcycle Helmet Law

Another attempt to mandate the wearing of helmets.

### 6—Practice Acts for "Sunset" Review This Year

The clinical psychologists and social workers must justify the existence of their boards this year. There will be an effort to consolidate all such practitioners under one board, but each entity will fight for its own.

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The following is a special report from the Colorado Medical Society Director of Communications concerning recent developments in the national and local communications of medical information.

#### WHO ACTUALLY COMMUNICATES MOST MEDICAL INFORMATION?

During the first week of December, I attended the International Conference of the Radio Television News Directors Association, held at Hollywood, Florida. This was one of the most effective such conferences I have ever participated in, after many years involvement with the organization and radio, television and newspaper writing, editing and reporting. The primary reason is that this conference dealt, majorily, with the information and reporting needs of industrial, corporate and business organizations as they relate to the public media. Was there a special emphasis on medical news? Not necessarily; however, the conference participants pointed up the similarity between the business-industrial community and the medical community.

#### HOW DOES A CEREAL FOODS COMPANY RESEMBLE THE MEDICAL PROFESSION?

One of the most meaningful programs included in the RTNDA conference was one entitled "Business Talks Back." Panelists included Robert A. Beck, chairman of the Board, Prudential Insurance Company of America, Brewster Bewater, Jr., President and Chief Executive Officer of General Mills, and Donald V. Rhody, Corporate Vice President for Public Relations and Advertising, Kaiser Aluminum Chemical Company. AND THERE IS A DISTINCT SIMILARITY BETWEEN INSURANCE, BREAKFAST FOODS, ALUMINUM PRODUCTS AND THE MEDICAL PROFESSION!

In recent years General Mills Foods Division has been under fire in the public media concerning the food or nutritional value of their cereals. It has been conceded that most of the information communicated by the various public news organs was gleaned from federal government reports. Little of the actual report material came from the manufacturer itself, though the manufacturer was most often the object of the report.

Other reports over the past decade dealt with the value of "whole life insurance," again the result of federal government agency reports and information which was fed to the public news media. In the case of General Mills, the reports sprang from the (then) Department of Health, Education and Welfare. In the latter case, the initial reports were the output of the Federal Trade Commission's investigation into life insurance. Prudential insurance was certainly included in the broad statements made from this investigation.

Most recently, ABC's "20/20" program did a segment (approximately 20 minutes long) concerning the sale and use of aluminum wiring in U. S. homes. The report implied that such wiring was "unsafe" and that the manufacturer knew this. To skip the details, Kaiser then asked for equal time to tell its side of the story, saying that the report was not factual as aired by ABC. The thrust of their requests has been that industry was not afforded adequate opportunity to respond to such charges and that, after the fact, the industry had difficulty in getting the chance to reply on public media. This latter case will result in some type of litigation.

(continued)

## COMMUNICATIONS REPORT (continued)

WHAT DOES ALUMINUM WIRING HAVE TO DO WITH MEDICINE AND PRIVATE PRACTICE?

I make this report only because medicine has been treated in the same manner as business and industry in recent years. I DO NOT indict the general news media for this treatment! Having been in the business of news for many years I feel that the media, the journalists, the reporters and editors, have done a creditable job with honesty and integrity in most instances. So then..... what's the problem?

In the decade of the '80s the focus of most public attention will be on human services. The American people have demonstrated their turn toward more conservative attitude, realizing that it will be up to them individually, to be able to protect themselves from the ravages of inflation, self-serving government programs, problems of unemployment, lower productivity and all the other ills of a government that is determined to bring all things to all people, with the major industry being the scapegoat in most cases. Because of this new focus on "the things I must have as an individual," there will be much more attention given to health care and medical treatment. People want to know, and their chief source of information today is through the public media. If those media continue to depend on government studies, reports, investigations and government new services to get the information about these human services, your profession will continue to be on the carpet for answers to questions which were inspired, through the public news media, by the government.

WHAT'S THE ANSWER? YOU, THE PHYSICIAN, HAVE TO PROVIDE THE INFORMATION...FIRST!

You, as a member of the medical profession, must supply the question AND the answers....first! We, as the COLORADO MEDICAL SOCIETY, must be PRO-ACTIVE! We MUST make that information available to the public (and, as a result, to the public news media) to allow for a well-informed public which is the only protection against a distorted view of the practice of medicine.

I want to start a campaign....yes, a campaign! I want you, as a CMS member and as a private-practice physician, to help in properly informing the public. We'll even have campaign buttons. The buttons will say: 'ASK ME ABOUT MEDICINE.' CMS will be happy to provide the answers to an individual or to any media person. If business and industry had done this ten years ago they wouldn't have suffered the misunderstandings and the costs involved in having to fight distortion and misstatement in advertising, in news media and in the courts. We want people to know what the medical profession is doing concerning cost-efficiency; we want the public to be as well informed about past, present and future medical advancement as possible. We want that information to come from the physicians....not from the third-party purveyor of the outside view.

Yes, I believe the radio, television and newspaper news reporters and editors are doing a good job....with what they have to work with. That's not enough for your profession. These people, and they are people, have to have the best possible information concerning medicine, and that information has to come from the practitioners, themselves. Colorado Medical Society I am your spokesman. Help yourself by helping CMS to make the best use of this news resource!

Bill Pierson  
Director of Communication  
Colorado Medical Society



# Highlights of the CMS Board of Directors Meeting, December 4, 1980

1. Moved to approve recommendation of Council on Interprofessional Relations that the state's current nurse practice act, allowing nurses to become R.N.'s through associate degree, diploma, or baccalaureate programs is appropriate and that the nurse practice act not be ammended.

2. Supported the Council on Interprofessional Relations' recommendation that the CMS Council on Legislation consider changes in the state pharmacy laws precluding the Board of Pharmacy from registering physicians as outlets.

3. Supported the Council on Interprofessional Relations' request that the Council on Legislation cooperate in developing legislation on controlled substances.

4. Supported recommendation of the Council on Public Health to forward a letter to Governor Lamm urging him to seek emergency funding for the continuation of the Community Maternity Program providing medically indigent maternal and newborn care.

5. Moved to support the Council on Public Health's recommendation to forward a letter to Governor Lamm requesting Colorado's leadership role in developing a solution to the problem of radioactive waste disposal which is threatening patient care and research in the state.

6. Move to support Council on Public Health's requests that the Board of Directors approve distribution of a letter to the presidents of component societies offering education programs on the effects of low-level radiation.

7. Approved membership classification changes: Active Member Emeritus - 15; Active Member On Leave - 7; Junior I - 1.

8. Approved charging an administrative fee for all non-member physicians utilizing the Physician Placement Service.

9. Approved disbursement of interest income of Cochem's Trust Fund to a physician in need of financial aid who met established criteria.

10. Approved additional membership benefit with endorsement of the Hertz Association for car rental discounts.

11. Approved the following 501 (c) (3) organizations as recipients of funds from the Colorado Foundation Trust: Colorado Health Careers Council. \$5.000; Colorado State Science Fair. \$450; Hall of Life. \$2.720; Rural Health Manpower Consortium. \$3.720.

12. Voted to ask Council on Legislation to look into Malpractice Reform and current Colorado statutes and report back to the Board of Directors.

13. Approved recommendation of the Council on Professional Education that the CMS accept a grant, if offered, from the Colorado Department of Health to support the dissemination of a curriculum on alcoholism and drug

(continued)

## BOARD OF DIRECTORS MEETING (continued)

abuse in patients, through the Colorado Consortium for Continuing Medical Education.

14. Moved to officially sponsor a Negotiating Seminar for CMS leadership on June 27-28, 1981. Registration fee will be \$195.00. There will be 13 hours CME credit.

15. Approved sending LeeAnn Pearse as student representative to the AMA meeting in San Francisco.

16. Medicaid Reimbursement: The Board received reports from Dr. Ray Painter, Chairman of the Council on Socio-Economics; Dr. Noel Sankey, Chairman of the Negotiating Committee; Mr. Lawrence Wood, Legal Council; and heard discussion from members of the Board. Motion was carried that at this time the CMS continue gathering data concerning inadequate Medicaid reimbursement. The Board approve the Negotiating Committee, through its Chairman, Noel Sankey, as CMS spokesmen in trying to achieve an increased level of payments for Medicaid services through continued lobbying with the Joint Budget Committee and negotiations with the Department of Social Services.

The Board accepted recommendations from the Council on Socio-Economics that CMS collect data by a) developing and implementing a survey which would allow collection of the data needed for effective negotiations; and b) working with Blue Cross/Blue Shield and the Department of Social Services to attain existing data.

ALL BOARD MEMBERS WERE PRESENT.

# *Is there a doctor on the road or at the game?*



The Committee on Medical Aspects of Sports of Colorado Medical Society hopes to hear from physicians who share its members' interest and concern about medical coverage of running events and interscholastic athletic contests.

Please let us know if you are interested in participating in your community.

INTERSCHOLASTIC GAMES:

RUNNING EVENTS:

Names of sports: \_\_\_\_\_

Please mail to:

David C. Greenberg, M.D.

Chairman

Medical Aspects of Sports Committee

Colorado Medical Society

1601 E. 19th Avenue

Denver, CO 80218

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_



## Update on Possible Legislative Issue

The following issues will probably surface during the 1981 legislative session. The first five were reported as bills from the interim Judiciary committee and will undoubtedly be given the seal of approval by the Council on Legislation. The other three are not yet in bill form.

1. SHORT-TERM CARE AND TREATMENT OF THE MENTALLY ILL.
2. PROCEDURES FOR THE CARE AND TREATMENT OF THE MENTALLY ILL.
3. PROCEDURES IN THE CRIMINAL INSANITY STATUTES.
4. CONCERNING THE CONDITIONAL RELEASE OF MENTALLY ILL PERSONS COMMITTED UNDER CIVIL PROCEEDINGS.
5. CONCERNING CONDITIONAL RELEASE FROM CONFINEMENT AFTER A VERDICT OF NOT GUILTY BY REASON OF INSANITY.

6. DMSO-We are told that representative Jean Larson (R), El Paso, will probably introduce a bill concerning DMSO that will be similar to the bill of two years ago allowing the use of laetrile.

7. PODIATRY-The podiatrists will try, via the Nurse Practice Act, to gain full prescriptive powers.

8. CERTIFICATE OF NEED-Senator Fred Anderson (R), Ft. Collins, is seriously considering repealing all or part of the certificate of need law.

As of this date, it appears that physician assistant, child health associate, use of drugs by optometrists, and hospital rate review legislation will not be introduced. The optometrists will have some sort of legislation on continuing education.

## Highlights of Minutes, Council on Professional Education, November 19, 1980

Chairman Patrick Moran, M.D. appointed an ad hoc committee of the Council to recommend a plan for improved educational liaison with the University of Colorado School of Medicine. This was in response to a resolution on support for the Medical School by the 1980 Annual Session of the House of Delegates. The committee is comprised of Drs. Harry Locke (Chairman), Franklin Yoder and Kenneth Furlong. The committee will report its initial recommendations at the February 4th meeting of the Council.

Responding to another goal set at the 1980 Annual Session, Council elected an ad hoc committee to begin formulating a plan concerning the CMS's future role in professional education. This plan is to be presented at the 1981 Annual Session for approval of the House of Delegates. The committee is comprised of Drs. Kenneth Furlong (Chairman), William Shiovitz and Patrick Moran. Staff has already begun polling other medical societies and

(continued)

#### COUNCIL ON PROFESSIONAL EDUCATION (continued)

associations to determine if similar studies have been done in those states.

Responding to a request from the Denver Medical Society, the Council voted to recommend to the CMS Board of Directors that a possible grant from the Colorado Department of Health be accepted by CMS, and the Colorado Consortium for Continuing Medical Education be designated to implement it. Purpose of the grant would be to disseminate a curriculum on treating alcoholism and drug abuse in the doctor's office to outlying sites in the state.

Council will meet on the following dates in 1981: February 4, May 6 and August 5. The November meeting will be scheduled at a later time.

## Liberal Education for Practicing Physicians

Dean of the School of Medicine, Roy Schwarz, M.D., is fond of telling the story of Alexander the Great. As a 28-year-old general, Alexander conquered the known world to the Ganges River. There his troops refused to go farther saying they had reached the edge of the world.

So he returned to Sodom and after partaking of the evils of that place, died at the age of 30.

Too many physicians follow careers like Alexander's. As young men, they are brilliant and creative researchers, teachers or practitioners. But by mid-life, they are living in an intellectual tunnel; their practice has lost much of the excitement it had for them in earlier years, and they are ready for new perspectives--new ways of thinking--new knowledge.

The Board of Managers of the Colorado Consortium for Continuing Medical Education has recognized this problem and is in the process of taking a closer look at it. They are identifying people in the state of Colorado who are interested in the bridge between the practice of medicine, and "liberal education".

Long term plans call for the Consortium to seek funding to develop a program in Colorado to help local groups of physicians organize educational programs for doctors on topics not related to medicine -- topics which broaden perspectives, stimulate creative imagination, expand the physician's view of his role in society, and ultimately make him or her a more effective practitioner of medicine.

The consortium is interested in hearing from physicians who would be interested in participating in such a program. Those who would like to be put on a mailing list to receive further information concerning liberal education in medicine as it becomes available should write to: Kevin P. Bunnell, Ed.D., Executive Director, Colorado Consortium for Continuing Medical Education, 1601 E. 19th Ave., Denver, CO 80218. Phone (303) 861-1221 ext. 262 (toll free outside the metro Denver 1-800-332-4150).



# Medical Society Notes

## WELD COUNTY MEDICAL SOCIETY

Judy Zebrowski is no longer the Executive Secretary of the Weld County Medical Society. Chris Ryan has taken that position. The address and the telephone number will remain the same.

## MEDICAL SOCIETY RADIO PROGRAMS

Denver Medical Society and Clear Creek Valley Medical Society have been conducting a cooperative venture into public affairs programming for radio stations in the Denver area. SPEAKING OF MEDICINE has been a weekly, half-hour program aired on KLAQ and KPPL-FM for the past 26 weeks. Clear Creek Valley President Herman Doyle, MD, and Denver President J. Phillip Nelson have decided to continue the programs on a weekly basis.

Both societies are interested in making optimum use of the programs, which are of a general medical information nature, and encourage other physicians to contact either society if radio stations in their areas might be interested in using the half-hour programs. The CMS Division of Communications will continue to work with both societies and aid in the production of the program during the next year. The programs can be used in their present structure on any radio station in the state, so don't hesitate to make use of this resource.

If you have ideas for such programs, on a continuing basis, for stations in the area of your own component society and would like further information on setting up such a program, contact the Communications Division office at CMS, 861-1221, or 1-800-332-4150. We'll be happy to consult.

## NEWS OF EYE CARE

Kenneth R. Hovland, MD, Denver eye physician and associate clinical professor of ophthalmology at the University of Colorado Medical Center, received the American Academy of Ophthalmology's 1980 Honor Award for his outstanding service to the profession. The award was presented in Chicago at the opening ceremonies of the Academy's annual meeting, November 2 - 7.

Dr. Hovland was one of a number of Academy members honored for contributions in continuing education at the world's largest meeting on scientific advances in eye care.

## OPERATION REDDI....HELP FOR THE SOBER COLORADO DRIVER

The Colorado executive, judicial and legislative branches of government are very concerned about the growing number of automobile injuries and fatalities which are directly linked to drinking while driving.

One of the primary concerns is that it is not the drunken driver who is the victim of this unthinking offender. Therefore, a citizen awareness program has been instituted. Information concerning OPERATION REDDI (Report Every Drunk Driver Immediately) will be printed in COLORADO MEDICINE, with the approval of the magazine's physician advisors, and further information concerning OPERATION REDDI will be made available through the CMS Division of Communications.

(continued)

## MEDICAL SOCIETY NOTES (continued)

The Colorado State Patrol and Department of Highways will make available to interested physicians brochures, posters, pamphlets and other information which can be displayed in offices and clinics in an effort to aid in this program. For further information, call REDDI at 757-9412, or call CMS Communications, 861-1221 or 1-800-332-4150.

## COMPAC Donations Hit the Bullseye

The Colorado Medical Political Action Committee enjoyed an 84% success rate with its contributions to the 1980 state candidates. A total of 81 checks were issued to individuals running for the state legislature. These funds are used to defray expenses incurred by the candidates in their bids for election.

COMPAC was revitalized during 1980 and now has approximately 500 members. The purposes of the Political Action Committee are:

1. To promote and strive for the improvement of government by encouraging and stimulating physicians and others to take a more active and effective part in governmental affairs.

2. To encourage physicians and others to understand the nature and actions of their government, as to important political issues, and as to the records of officeholders and candidates for elective office.

3. To assist physicians and others in organizing themselves for more effective political action and in carrying out their civic responsibilities.

The President of COMPAC is Dr. Leroy Sides. Secretary, Carol Sides, and Treasurer is H. R. Safford, III.

### Advertisement

**FOREIGN PHYSICIAN — passed ECFMG, does not have Colorado license. Would like to have a job in the para-medical field.**

**CALL: Jalal 427-1970**





## ChoiceCare— An Anniversary

After five years of operation in Northern Colorado, "ChoiceCare", described as one of the largest Independent Practice Associations (IPA) in the United States, was ordered by the Colorado Insurance Commission to be put into receivership and finally ceased operations on Dec. 31, 1979.

Today, ChoiceCare is still in receivership with assets of approximately \$1.3 million and with liabilities slightly greater than \$4 million.

Because of the questionable ability of ChoiceCare to reimburse medical services for the 3,500 patients enrolled in the pre-paid program, board members of the Physicians Service Corporation (PSC), which represents 90 per cent of the physicians practicing in Larimer County, voted in late 1979 to discontinue and even forego the payment of fees. Larimer and Weld County physicians, pharmacists, and hospitals individually absorbed from \$500 to \$80,000 worth of patients. Additionally the Department of Health, Education and Welfare (HEW) earlier erased a \$700,000 loan it gave to ChoiceCare in 1974.

### Other Attempts to Heal the Wounded HMO Are in Progress

On December 31, 1979, ChoiceCare turned its operations over to the State Insurance Commissioner J. Richard Barnes. This is the first time in the state's history an HMO has been taken over by the Insurance Commissioner's office, according to Deputy Commissioner Daniel Colaianna.

Barnes is now seeking relief in the form of appropriations to aid the subscribers of ChoiceCare now facing outstanding medical bills as a result of the demise of ChoiceCare. The Insurance Commissioner said he has proposed an appropriation of approximately \$700,000. Barnes intends to provide reimbursements to physicians and hospitals from the grant, should it be adopted. He believes he has won

the support of several members of the state's congressional delegation.

Richard Sherman, Special Deputy for the receivership of ChoiceCare said on Nov. 12, 1980, that with the deletion of the previous \$700,000 loan by HEW, preliminary figures show that ChoiceCare creditors will receive about 60 cents for every dollar owed. However, legislation proposed by Barnes would provide federal funds to allow dollar for dollar payment of the ChoiceCare subscribers who have outstanding claims against the HMO.

Commissioner Barnes said he will also seek federal funds to reimburse physicians, pharmacists, and hospitals who are owed money by ChoiceCare for actual care provided to their subscribers, but will not make pleas for additional expenses for ChoiceCare.

The HMO concept was promoted by the Nixon Administration to offer an alternative financial mechanism for providing total health care for the patient. Federal monies were available in the form of grants to promote and develop HMOs. The ChoiceCare program of Northern Colorado required that employers in Larimer and Northern Colorado who employ more than 25 people must offer HMO as an alternative health insurance. Insurance Commissioner Barnes and the majority of the area doctors believe the government should appropriate the funds because "there were employers who did not want to offer ChoiceCare to their employees, but were forced to by the government," Barnes said.

ChoiceCare had a reported 26,000 commercial group enrollees, some 2,700 individual members, 6,300 Medicaid and 3,800 Medicare participants, according to the State Insurance Commissioner's office. One of the largest subscribers to ChoiceCare was Hewlett Packard.

"Hewlett Packard has filed their third suit against HMOs. Programs similar to ChoiceCare have collapsed in California, Idaho as well as Colorado," Colaianna told *Colorado Medicine*.

The residual effect of the collapse of ChoiceCare includes not only substantial amounts of financial debts, but also bad memories and leary attitudes toward HMOs in general. "ChoiceCare has left us with a very sour taste," Dr. John Malony, president of the PSC, commented. "Most of the physicians in the area are not to optimistic about receiving reimbursements."

"Most of the Weld County area doctors took their ChoiceCare balances, chewed them up and gulped them down with great difficulty. With even the mention of ChoiceCare it is possible it could all be regurgitated, the doctors get so angry," said Tom Heberline, business manager at the Greeley Women's Clinic.

No final decision will be made concerning the \$700,000 aid until Barnes makes his plea before the

(Continued on page 449)

*New books received are acknowledged in this section and such acknowledgment must be regarded as sufficient return for the courtesy of the sender. Selection will be made for review in the interests of our readers and as space permits. Books are listed with advance data supplied by publishers. Prices quoted are not guaranteed. For further information, address queries to the publishers. Books here listed are available for lending from the Denver Medical Society Library.*

## CARDIOVASCULAR SYSTEM

**BELLET'S ESSENTIALS OF CARDIAC ARRHYTHMIAS.** Samuel Bellet. 2nd ed. Philadelphia, Saunders, 1979. 389 p. \$27.50.

**CURRENT CONTROVERSIES IN CARDIOVASCULAR DISEASE.** Elliot Rapaport, ed. Philadelphia, Saunders, 1980. 761 p. \$39.50.

**THE HEART: UPDATE III:** J. Willis Hurst, ed. N.Y., McGraw-Hill, 1980. 171 p. \$30.00.

**HEART DISEASE.** Eugene Braunwald, ed. Philadelphia, Saunders, 1980. 2 v. \$60.00.

**PERIPHERAL VASCULAR DISEASES.** E.V. Allen. 5th ed. Philadelphia, Saunders, 1980. 981 p. \$40.00.

**TECHNIQUES IN VASCULAR SURGERY.** Denton A. Cooley and Don C. Wukasch. Philadelphia, Saunders, 1979. 282 p. \$45.00.

## GASTROINTESTINAL SYSTEM

**DISEASES OF THE EXOCRINE PANCREAS.** Frank P. Brooks. Philadelphia, Saunders, 1980. 139 p. (Major problems in internal medicine, v. 20). \$19.50.

## ENDOCRINE SYSTEM

**CLINICAL DIABETES.** Stephen Podolsky. N.Y., Appleton-Century-Crofts, 1980. 633 p. \$30.00.

**SURGERY OF THE THYROID AND PARATHYROID GLANDS.** C. Sedgwick and B. Cady, ed. 2nd ed. Philadelphia, Saunders, 1980. 241 p. (Major problems in clinical surgery, v. 15). \$19.00.

## PSYCHIATRY

**THE ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH NATIONAL DATA BOOK.** U.S. Department of Health and Human Services. Washington, D.C., G.P.O., 1980. 149 p. Gift.

## SURGERY

**PROGNOSIS OF SURGICAL DISEASE.** Ben Eiseman. Philadelphia, Saunders, 1980. 534 p. \$35.00.

## GYNECOLOGY

**AMBULATORY CARE IN OBSTETRICS AND GYNECOLOGY.** George M. Ryan, ed. N.Y., Grune & Stratton, 1980. 510 p. \$43.50.

(Continued on page 437)

## Reapportionment (Continued from page 426)

According to a U.S. Bureau of the Census release, fifty congressional districts lost five percent or more of their population in these years. Forty-six of these were urban districts; and the list included fourteen of the fifteen districts held by black House members. (Republicans take note: forty-seven of the fifty districts are presently held by Democrats.) It is the suburban fringes of the large metropolitan areas that have experienced major population increase.

Historically the Colorado General Assembly has been charged by the Constitution to reapportion the seats in the legislature after each decennial census. The party in control has tended to draw new district lines that favor the party's candidates (a process called "gerrymandering") within the confines laid down by the U.S. Supreme Court that districts must be "as near as may be" in population. The Colorado Constitution also spells out that the districts shall be compact, contiguous, and near equal in population.

In 1981, Colorado will be doing things differently. A constitutional change, successfully lobbied by Common Cause and by the League of Women Voters and voted on favorably by the citizens of Colorado in 1974, set up a body called the Colorado Reapportionment Commission. It consists of eleven electors: four are from the General Assembly - the Speaker of the House, the minority leader of the House, the majority and minority leaders of the Senate; four members appointed by the Chief Justice of the Colorado Supreme Court; three members appointed by the Governor. At least one member must be from the western slope. This commission will reapportion the General Assembly districts, and the General Assembly will continue to redraw the congressional districts.

The districts may not have over 5% deviation between the most populous and least populous districts in each house of the legislature. In drawing the districts the aggregate linear distance of all district boundaries shall be as short as possible; and must encourage the preservation of communities of interest (including ethnic, cultural economic, trade area, geographic and demographic factors) within a single district whenever possible, and discourage the splitting of cities and towns between districts. Once a plan is formulated, publication of the plan and public hearings in several areas of the state is required. Ultimate approval of the reapportionment plan is by the Colorado Supreme Court.

Politically what does all of this mean in Colorado? Obviously the legislative foursome is evenly divided politically. The governor is a Democrat; the Chief Justice is a Republican, though under constraint to

(Continued on page 446)



**Legislative Issues** (Continued from page 426)**7—Mandatory Disclosure of Hospital and Physician Costs and Charges**

Such a bill could take many forms but would probably take the form of Senator Hughes' bill of 1979. It required disclosure of all charges prior to treatment.

**8—Revival of Colorado Hospital Commission**

Some cost containment legislation is inevitable, especially since the Health Department is footing the bill for a dramatic conference on the subject in December. The governor is determined on this subject.

**9—Abused Adults**

For two years bills have been defeated that would have created legislation similar to child abuse legislation addressing the "battered" elderly or incompetent person. It will be tried again.

**10—Protection for Physicians and Hospitals Consonant with "Right to Refuse" Treatment**

The psychiatrists are investigating the need for this bill and may well introduce one.

**11—Health Care Technicians**

This new category of health care personnel, created at Denver General Hospital, may force legislation granting nurses supervisory privileges they do not now have.

**12—Right-to-Die**

Legislation spelling out numerous "legal" ways to end life for a terminally ill patient has failed to pass two different times. Its previous sponsor is not running for re-election, but someone will probably introduce a similar bill.

**13—Definition of Death**

A bill defining death to include brain death will be introduced for the second time.

**14—Osteopathic Grants**

The osteopaths are seeking grants of \$15,000 a year for each of 10 students who must go to other states for their schooling.

**16—Physician Assistants**

A second attempt will be made to clarify what a Physician's Assistant can do and how he may be disciplined under the Medical Practice Act.

**17—Controlled Substances**

A second effort will be made to pass the Uniform Controlled Substances Act and provide conformity between Colorado's laws with those of the federal government. It would seem simpler to expand the

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**INFECTIONS IN OBSTETRICS AND GYNECOLOGY.** David Charles. Philadelphia, Saunders, 1980. 440 p. (Major problems in obstetrics and gynecology, v. 12). \$32.50.

**OBSTETRICS**

**CURRENT THERAPY IN OBSTETRICS AND GYNECOLOGY.** Edward J. Quilligan. Philadelphia, Saunders, 1980. 223 p. \$22.50.

**WILLIAM'S OBSTETRICS.** J.A. Pritchard and P.C. MacDonald. 16th ed. N.Y., Appleton-Century, 1980. 1179 p. \$48.50.

**PEDIATRICS**

**TEXTBOOK OF CHILD NEUROLOGY.** John H. Menkes. 2nd ed. Philadelphia, Lea & Febiger, 1980. 695 p. \$38.00.

**OTORHINOLARYNGOLOGY**

**CONTROVERSY IN OTOLARYNGOLOGY.** J.B. Snow, ed. Philadelphia, Saunders, 1980. 561 p. \$40.00.

**PRINCIPLES OF HEAD AND NECK SURGERY.** H.R. Freund. 2nd ed. N.Y., Appleton-Century, 1979. 459 p. \$42.50.

**HOSPITALS AND OTHER HEALTH FACILITIES**

**THE HOSPITAL THAT ATE CHICAGO.** George R. Fisher. Philadelphia, Saunders, 1980. \$10.45.

**RECENT ACQUISITIONS****PHYSIOLOGY**

**SPORTS MEDICINE AND PHYSIOLOGY.** R.H. Strauss, ed. Philadelphia, Saunders, 1979. 441 p. \$16.95.

**SPORTS MEDICINE FOR THE ATHLETIC FEMALE.** Christine E. Haycock, ed. Oradell, N.J., Medical Economics, 1980. 412 p. \$27.50.

**PHARMACOLOGY**

**THE PHARMACOLOGICAL BASIS OF THERAPEUTICS.** L.S. Goodman and Alfred Gilman, ed. 6th ed. N.Y., Macmillan, 1980. 1843 p. \$45.00.

**PATHOLOGY**

**CANCER TREATMENT.** Charles M. Haskell. Philadelphia, Saunders, 1980. 1133 p. \$25.00.

**IMMUNOTHERAPY OF HUMAN CANCER.** Clinical Conference on Cancer, 22nd, Anderson Hospital and Tumor Institute, 1978. N.Y., Raven Press, 1978. 417 p. Gift.

**MEDICAL PROFESSION**

**THE AMERICAN HEALTH CARE SYSTEM, ISSUES AND FACTS.** American Medical Association. Chicago, A.M.A., 1980. 56 p. Gift.

**HANDBOOK OF LEGAL MEDICINE.** Charles S. Hirsch. 5th ed. St. Louis, Mosby, 1979. 378 p.

**SERVICING THE PROFESSIONAL CORPORATION.** Steven K. Riemer. Englewood Cliffs, N.J., Prentice-Hall, Inc., 1979. 230 p. \$34.95.

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#### **PUBLIC HEALTH**

**THE BATTERED CHILD.** C. Henry Kempe and Ray E. Helfer. 3rd ed. Chicago, U. of Chicago Press, 1980. 440 p. \$25.00.

#### **PRACTICE OF MEDICINE**

**THE PRINCIPLES AND PRACTICE OF MEDICINE.** A.M. Harvey and others, ed. 20th ed. N.Y., Appleton-Century-Crofts, 1980. 1569 p. \$38.50.

**WHAT ARE MY CHANCES?** Ben Eiseman. Philadelphia, Saunders, 1980. \$14.95.

#### **IMMUNOLOGIC DISEASES**

**ALLERGIC DISEASES.** Roy Patterson. 2nd ed. Philadelphia, Lippincott, 1980. 714 p. Gift.

**ALLERGIC DISEASES OF INFANCY, CHILDHOOD AND ADOLESCENCE.** C.W. Bierman and D.S. Pearlman, ed. Philadelphia, Saunders, 1980. 837 p. \$49.50.

#### **METABOLIC DISEASES**

**OBESITY.** Albert J. Stunkard. Philadelphia, Saunders, 1980. 470 p. \$29.00.

#### **MUSCULOSKELETAL SYSTEM**

**BONE TUMORS.** Joseph M. Mirra. Philadelphia, Lippincott, 1980. 629 p. \$69.50.

**CAMPBELL'S OPERATIVE ORTHOPAEDICS.** A.H. Crenshaw and A.S. Edmonson, ed. 6th ed. St. Louis, Mosby, 1980. 2 v. \$175.00.

**COMPLICATIONS OF HEAD AND NECK SURGERY.** John Conley. Philadelphia, Saunders, 1979. 524 p. \$35.00.

**PRACTICAL ELECTROMYOGRAPHY.** E.W. Johnson, ed. Baltimore, Williams & Wilkins, 1980. 457 p. \$59.50.

**TEXTBOOK OF RHEUMATOLOGY.** W.W. Kelley and others. Philadelphia, Saunders, 1981. 2054 p. \$104.00.

#### **RESPIRATORY SYSTEM**

**MANAGEMENT OF THORACIC EMERGENCIES.** John Borrie. 3rd ed. N.Y., Appleton-Century-Crofts, 1980. 500 p. \$38.50.

**PULMONARY DISEASES AND DISORDERS.** Alfred P. Fishman. N.Y., McGraw-Hill, 1980. 2 v. \$129.00.

#### **HOW TO USE MEDLINE**

For computerized literature retrieval, call Martha Burroughs, Denver Medical Society Reference Librarian, on the free WATS in-line, 1-800-332-4150. She will contact the National Library of Medicine computer to request the needed information. Immediate transmission of citations to material published since 1979 will take place, while literature published since 1966 can be obtained in less than a week.

## **THE HAZARDS OF RADIATION AND THE ROLE OF THE PHYSICIAN**

In the public health arena, there is no issue more subject to emotional rhetoric and less subject to factual reasoning than the potential health impact of exposure to ionizing radiation. This issue receives so much coverage by the public media that scarcely a day passes without some new revelation about the exposure of the public to radiation from one source or another. Frequently the exposure is portrayed in such an alarmist, anti-establishment fashion that one can understand why the public is shifting increasingly into an anti-radiation, anti-nuclear posture. This shift is openly encouraged by political action and consumer protection groups who use partial information, and sometimes misinformation, in pursuing their goal of impeding nuclear development activities around the country. On occasion, these groups are aided by dedicated but unenlightened public servants and members of the public who express their anxieties about radiation exposure without formulating a data base sufficient to justify or quell their anxieties. The composite effect of all these activities includes the halting of nuclear power development in this country and the instilling into some patients of an unwillingness or reluctance to undergo medical examinations and treatments which require exposure to radiation.

Many of you will recall the heightened public concern that developed in this country in the early 1960's over the need for fallout shelters to protect families against nuclear attacks. Hours were spent debating the ethics of defending the shelter against invasion by neighbors with less foresight who had not built a shelter. At that time, the major concern was the undocumented but presumed genetic disaster that would befall our society if families were exposed to low levels of radiation. Advertising brochures from companies marketing fallout shelters portrayed Japanese children with large keloids which were attributed to exposure of the children's parents to radiation prior to conception. Over the decade of the 1960's, public concern over the genetic effects of radiation remained unabated even though scientific evidence continued to accumulate that genetic risks of radiation exposure were considerably lower than suspected originally. This evidence was summarized in a 1972 report of the National Academy of Sciences<sup>1</sup> in which the genetic consequences of radiation exposure were identified as less than the carcinogenic effects of exposure to radiation. With this report, the era of "cancer risk" replaced the era of "genetic risk" in the study of possible radiation bioeffects.

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## Drug Therapy Questions and Answers

Christopher S. Conner, Pharm.D., Director, Rocky Mountain Drug Consultation Center, Denver General Hospital, Assistant Professor of Medicine, University of Colorado Health Sciences Center and Dennis R. Sawyer, Pharm.D., Associate Director, Rocky Mountain Drug Consultation Center, Denver General Hospital, Assistant Professor of Medicine, University of Colorado Health Sciences Center.

This column is designed to provide Colorado physicians with specific answers to commonly asked questions regarding drug therapy. The column is prepared by the Rocky Mountain Drug Consultation Center in Denver. All questions appearing in the column were generated from calls received by the Rocky Mountain Drug Consultation Center from physicians and other health professionals.

Physicians may call the Rocky Mountain Drug Consultation Center at (303) 893-DRUG to obtain specific answers to any drug therapy questions, including adverse drug reactions, drug interactions, drug therapy of choice, investigational drugs, drug use in pregnancy, drug dosing in renal and hepatic failure, and drug identification. The Center is available from 8:00 a.m. - 6:00 p.m. Monday through Friday, with 24 hour on call service.

This issue we present two recent consultations regarding the use of drugs in pregnancy.

### NITROFURANTOIN IN PREGNANCY

#### **Request:**

What are the risks of nitrofurantoin usage in pregnancy, and is there specific data available in regard to its usage in the presence of erythroblastosis fetalis?

#### **Response:**

Nitrofurantoin does not appear to be teratogenic. The records of 101 female patients receiving nitrofurantoin at a dose of 200-400 mg per day by mouth for asymptomatic bacteriuria were compared with those of 101 patients admitted during the same period who did not have bacteriuria and did not receive chemotherapy. In the treated cases, no adverse effects in terms of apgar scores, jaundice or congenital abnormalities were shown (Perry et al., 1967). Of 590 mothers receiving nitrofurantoin at various stages of pregnancy and 83 mothers receiving nitrofurantoin during lunar months 1-4, 14 and 6 children, respectively, were born with various malformations (Heinonen et al., 1977). The incidence of malformations in both groups is considered below the established crude relative risks in the populations studied.

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## new officers

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### DENVER MEDICAL SOCIETY (Continued from page 425)

#### **TREASURER**

Nancy Nelson, M.D.  
1265 Elizabeth Street  
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**ABOVE—**Darlene Classen at the Cancer Institute in Peking with Dr. Chu Chuan Yen, head of the cancer research department (left), and Dr. Wu Kan-Mei, head surgeon. **RIGHT—**Mrs. Classen at the Great Wall.

## Denver Medical Tour of The People's Republic of China August 7-25, 1980

China—900 million population—a beautiful, historic country with mountains, many lakes (some with huge lotus flowers), ground rich in farming—rice paddies, vegetables, orchards, trees planted everywhere—this was the wish of Chairman Mao. A country where people are curious of foreigners, respectful, friendly and trustworthy. Since the downfall of the Gang of Four, the cultural arts are being revitalized; posters of Chairman Mao are being removed and the democracy walls are restricted since the August meeting of the People's Congress. Dress of the people is changing from Mao jackets and baggy pants to more colorful blouses, shirts, and dresses. We had total freedom to come and go and shop as we pleased.

There were two National Guides and interpreters with us throughout our tour. In each city, we had two additional local guides. Our tour was a comprehensive medical tour. We visited the Peking Cancer Institute, the Tiger Park Sanitorium for Chronic Illnesses in Dailien, the Home for the Aged in Shen-

yang, the large medical institution—Hua Hospital in Shanghai—where we observed a left lobe thyroidectomy under acupuncture anesthesia, and 3 psychiatrists got to visit the mental institution in Shanghai. We got to see the contrast between the country and urban communes—visited their clinics and hospitals. The people were appreciative of the suture scissors, forceps and bronchoscope I presented.

We visited various factories—No. 2 cotton mill, locomotive, jade and ivory carving, shell and feather, and carpet.

There is much cultural talent among the Chinese people—attended the acrobatic and magic shows where my husband and I were invited to participate in one magic trick and also attended Chinese opera. We played table tennis with the natives. Two highlights of the tour were: visits to the kindergartener where these youngsters presented us with gifts of rice paper articles they folded; they performed dances, sang native folk songs and a 6-year-old girl played classical numbers on the piano; visit to the Children's Palace where we observed youngsters of all ages developing their skills—ballet, embroidering, art and music—heard an 18-year-old girl sing opera, a children's orchestra and a children's choir who asked us to sing for them. The director presented me a beautiful "musical note" pin.

China is rich and old in history. We visited the Forbidden City, Ming Tombs, and many temples in every city. Chairman Mao's mausoleum; our walk on the Great Wall was awesome. Shopping in the people's stores was delightful.

The cuisine was delicious and different in every region—we had as high as a 12 course meal and we became adept at using chopsticks. We ate Peking duck two times and had a good taste of the famous Mao Tais—many toasts!

We saw many people being treated with acupuncture for various problems. For the Chinese, this treatment, along with cupping and moxibustion, does cure. This is used along with a combination of herbal and western medicine. Other anesthesia used is spinal, ether or a local spray for tonsilectomies. The large hospitals will treat as many as 2,000 people per day as outpatients. Disinfection is done with lysol. Patients were respectful to our observing them and would walk to the door to greet us.

Birth control is practiced faithfully—the government allows one child per family (multiple birth is considered as one); the second child, parents pay a percentage of their salary to the government; the third child is totally the parents' responsibility, with no help from the government. Sterilization is done more on women than men.

The visit to the Peking Zoo to see the pandas was a delightful surprise. Everywhere we went, I had my panda hand puppet which performed—bringing much laughter and happiness.

(Continued on page 459)



# Paget's Disease of the Breast

## A Case Report

Robert M. Pash, MD, Joseph L. Glaser, MD, and Donald C. Kuzela, MD, Denver, Colorado

*In 1874 Sir James Paget described an eczematoid lesion of the nipple which was followed by the "formation of scirrhous cancer in the mammary gland".<sup>17</sup> Despite the fact that Paget's disease is a potentially curable form of breast cancer, recognizable on clinical appearance, delay in diagnosis continues to be a problem. We report the clinical summary of a patient with classic Paget's disease of the nipple and review the literature with special emphasis on the presentation of Paget's disease and its relationship to prognosis. Ideas on the histogenesis of the Paget's lesion will be discussed. A viewpoint of surgical management will be presented.*

## Comment

Paget's disease represents 0.7-4.1% of all mammary cancer and occurs most commonly in the 5th-7th decades of life.<sup>10,12</sup> Crusting, scaling, erosion, or discharge from the nipple occur in 90 per cent of patients with Paget's disease.<sup>11</sup> A breast mass is not palpable in approximately half of the patients. In view of Haagensen's statement that "any lesion of the nipple and areolar epithelium should be assumed to be carcinomatous until proven otherwise", the delay in diagnosis in this case is disconcerting.<sup>8</sup> However, delay in diagnosis beyond one year is not at all uncommon. Simple biopsy of the nipple lesion will be diagnostic in the majority of cases; however, if a breast mass is present, biopsy of the tumor is indicated. Xeromammography may aid in the localization of suspicious areas in the breast if tumor mass is not palpable. Prognosis and decisions regarding adjuvant treatment should be based on the size of the tumor and the presence or absence of nodal metastases.

## Discussion

Despite the fact that the diagnosis of Paget's disease of the breast can usually be made by inspection the duration of symptoms may often extend over many months. Haagensen<sup>8</sup> reported an

average delay of 15.2 months, Colcock and Sommers<sup>5</sup> 18 months, and Maier *et al.*<sup>12</sup> 13.6 months. McGregor and McGregor<sup>13</sup> reported that in 13 out of 21 patients the correct diagnosis was not made for at least 6 months following onset of symptoms. More recently, Freund *et al.*<sup>7</sup> found an average delay of 17.5 months from onset of symptoms to diagnosis of Paget's disease in 29 women; Malak and Tapolcsanyi<sup>11</sup> an average delay of 10.5 months in 73 patients; and Kister and Haagensen<sup>10</sup> an average delay of 13.5 months in 68 women with nipple changes alone. It is interesting that in Kister and Haagensen's study<sup>10</sup>, 42 women with Paget's disease and a palpable breast mass were diagnosed after an 11 month delay, whereas the average delay for all breast cancer at Columbia Presbyterian Medical Center was 8.3 months.

Delay in diagnosis, although common and apparently unchanged over the last decade, is still surprising as Paget's disease is neither silent nor invisible. Malak and Tapolcsanyi<sup>11</sup> found that patient delay was the cause of late diagnosis in 34 cases and that physician failure precipitated the delayed diagnosis in 22 patients. In general, a simple rule of thumb is that any area of redness, roughness, or thickening of the nipple and every erosion of the nipple, no matter how small or unimportant, should be biopsied.

Delay in diagnosis appears to be a secondary factor in relationship to survival. Maier *et al.*<sup>12</sup> divided 88 patients into short delay (6 months or less from onset of symptoms to diagnosis) and long delay (greater than 6 months) groups. In the short delay group, 16 out of 34 patients survived 5 years following treatment, whereas 22 out of 33 patients in the long delay group survived 5 years. They also found no difference in survival in either category when axillary nodes were found to be involved with metastatic tumor. Nance *et al.*<sup>16</sup> and Freund *et al.*<sup>7</sup> also found little or no difference in survival when diagnosis and treatment were delayed beyond 6 months.

Ashikari *et al.*<sup>1</sup> reported a 61.9 per cent 5 year survival in a group of patients whose diagnosis of

(Continued on page 444)



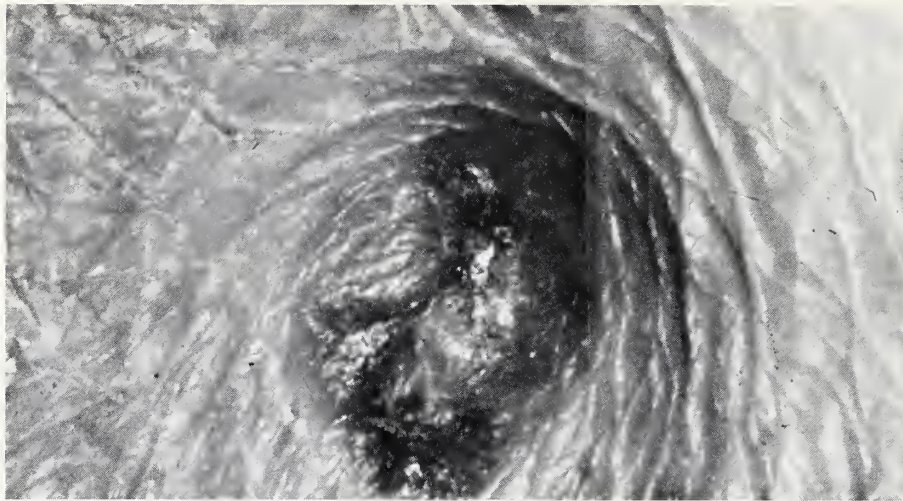


Fig. 1. Gross appearance of the nipple following biopsy.

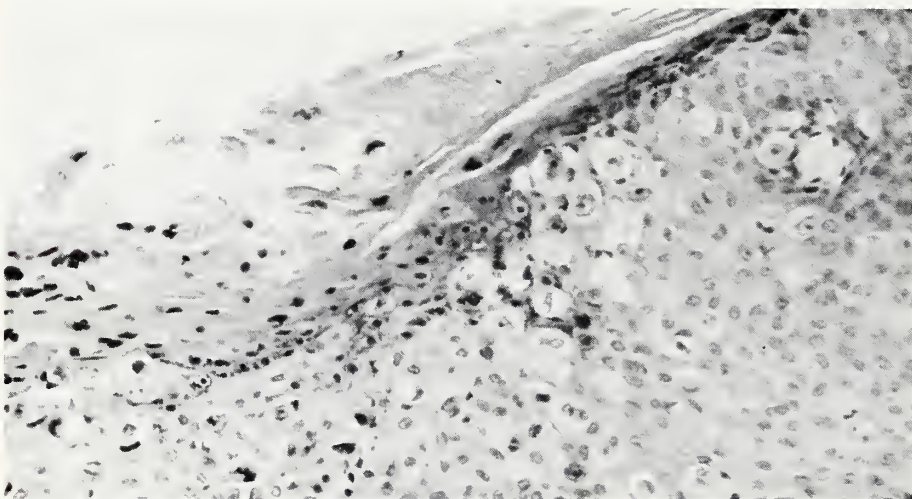


Fig. 2. The epidermis of the nipple is infiltrated by numerous Paget cells with abundant, pale cytoplasm and enlarged, pleomorphic nuclei.

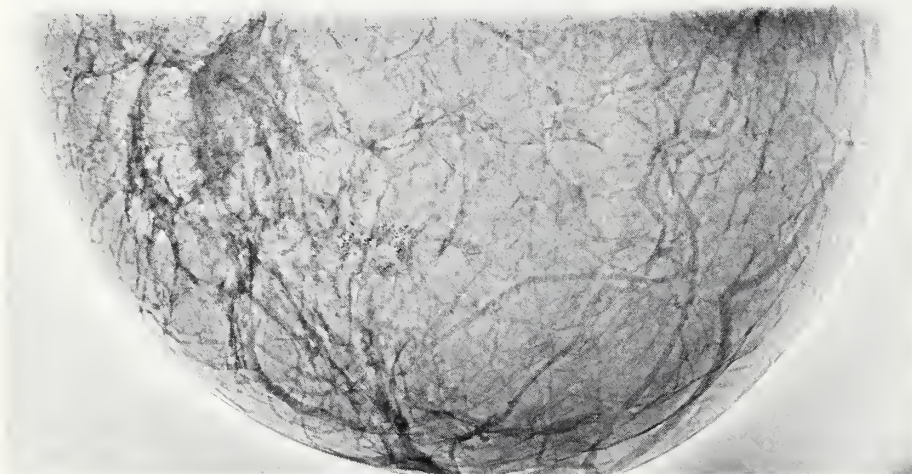
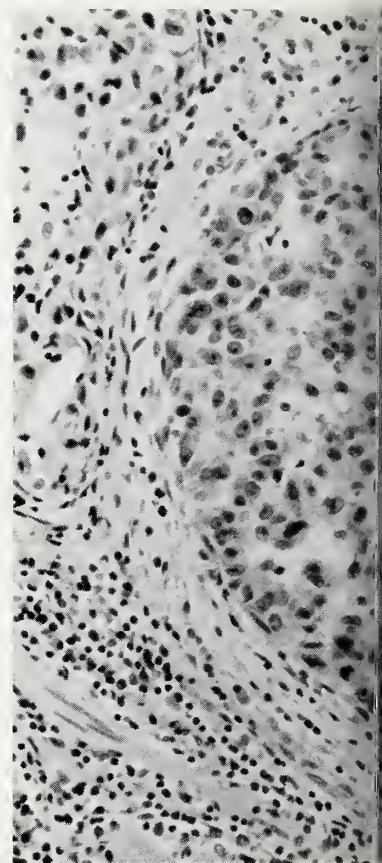
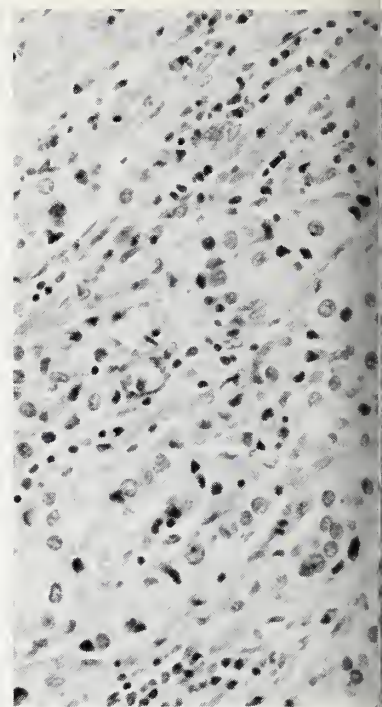


Fig. 3. Xeromammograms of the left breast revealing a poorly defined mass with groups of calcifications in the upper outer quadrant.





## CASE REPORT

R. L., a 63 year old, G XVI, P XIII, postmenopausal, white female, presented with a slightly tender, encrustation of the left nipple of one and one-half years duration. The lesion had drained occasionally, but there was no frank ulceration or bleeding. She had been previously examined by two separate physicians, and had been treated with topical agents without improvement of the lesion. There was no family or prior personal history of breast disease or carcinoma.

Physical examination revealed a slightly obese woman with large, pendulous breasts. No masses or areas of tenderness were apparent in either breast. There were no skin changes except for a firm, crusted area on the left nipple which extended inferiorly onto the areola (Fig. 1). The right nipple and areola were normal.

A dermal punch biopsy of the involved nipple showed Paget's disease (Fig. 2). Xeromammography of both breasts showed a highly suspicious area in the upper quadrant of the left breast (Fig. 3). Preoperative bone scan and liver profile were normal. The patient underwent a left modified radical mastectomy and was discharged after an uneventful recovery.

Lying beneath the crusted nipple of the mastectomy specimen was a 0.8 cm, poorly demarcated, firm white nodule. Purulent appearing material could be expressed from dilated ducts within the nodule. Three similar appearing, separate 2 to 4 cm, nodules were present within the upper outer quadrant of the breast. Histologically the tumor was a poorly differentiated, infiltrating duct carcinoma (Fig. 4) containing a prominent, in-situ (comedo type) component (Fig. 5). Although tumor invaded lymphatics within the breast tissue, axillary lymph nodes at all levels were without microscopic evidence of metastases. Tumor estrogen activity was absent (1.5 fM/mg).

Due to the multicentricity of the tumor and microscopic lymphatic invasion, the patient was referred for radiotherapy. The patient will be followed closely for any changes that may develop in the contralateral breast.

Fig. 4. Invasive component of the poorly differentiated duct carcinoma composed of infiltrative cords and nests of tumor cells without glandular differentiation.

Fig. 5. In situ component of the tumor showing intraluminal necrosis (comedo pattern).

TABLE I  
Survival in Paget's Disease  
% 5 year survival

	Overall 5 yr survival	Node Status		Palpable Mass No	Palpable Mass Yes	Delay in Diagnosis	
		-	+			Short	Long
Maier	52.3 (88)	86.1 (36)	23.3 (40)	70 (40)	37.5 (48)	47.8 (46)	57.1 (42)
Ashikari	69.2 (209)	88.9 (122)	31.8 (87)	92 (96)	42.5 (113)	61.9 -	64.1 -
Kister	58* (85)	79* (49)	28* (36)	81* (21)	47.4* (59)	-	-
Nance	54.7 (53)	-	-	94.1 (17)	40.6 (32)	52.6 (19)	63.3 (30)
Malak	76 (50)	80.5 (36)	64.3 (14)	88.2 (17)	72 (11)	-	-
Freund	74 (27)	-	-	94 (17)	40 (10)	-	-

\*% 10 year survival

## ACKNOWLEDGEMENT

We wish to acknowledge the assistance of the Department of Pathology and the Department of Medical Illustration, Rose Medical Center, Denver, Colorado, for providing us with illustrations.



(Continued from page 441)

Paget's disease was made in less than 6 months from onset of symptoms and a 64.1 per cent 5 year survival in a similar group whose diagnosis was delayed for longer than 6 months. There were, however, some important differences between the two groups. In the early diagnosed group, patients with nipple changes alone had a 6 per cent rate of axillary metastases, whereas the rate rose to 17 per cent of patients whose diagnosis was delayed beyond 6 months. In those patients who had both a nipple lesion and a palpable breast mass, axillary metastases were present in 62 per cent of the early diagnosed group; the percentage climbed to 73 per cent in the delayed group. Biologic tumor activity may explain why long delay is not equivalent to poorer survival rates. Perhaps women with symptomatically more aggressive lesions seek diagnosis sooner.

These statistics and statements are not offered in support of a policy of delayed treatment for Paget's disease. Malak and Tapolcsanyi<sup>11</sup> presented case histories of women whose delay in diagnosis may have been a contributing factor to fatal consequences. Early diagnosis in breast cancer can still be expected to salvage some women who otherwise might have a dismal prognosis.

The incidence of a palpable breast mass associated with Paget's disease varies from 33 to 69 per cent.<sup>7, 12</sup> When Paget's disease of the nipple is not associated with a palpable breast mass, survival appears to be better than that of breast cancer in general. Most authors have found that the prognosis in patients with Paget's disease and an associated breast mass is similar to that of all breast cancer. In either case axillary node metastases have been found to be the most important prognostic factor.

In the study by Ashikari *et al.*<sup>1</sup>, 65 per cent of 113 patients with Paget's disease and a discernible breast mass had axillary lymph node involvement, while only 13 per cent of 96 patients with nipple lesions alone had positive lymph nodes. In their report the 5 year survival of patients who had no palpable mass and negative nodes in the axilla was 96.8 per cent. Five year survival for patients with no palpable mass but positive nodes in the lower axilla was 80 per cent. Only 50 per cent of patients with high axillary node metastases survived 5 years.

In the same study, the 5 year survival for patients with Paget's disease and a palpable breast mass but negative nodes was 73 per cent. With positive nodes in the low axilla the 5 year survival was 41 per cent. Patients with nipple changes, a

palpable breast mass, and metastases in the high axillary nodes had the worst prognosis with only a 20 per cent survival at 5 years.

Nance *et al.*<sup>16</sup> found axillary metastases in 50 per cent of their patients with both a nipple lesion and a breast mass. Overall 5 year survival in this group was 40.6 per cent. None of their patients with nipple changes alone had axillary metastases, and all of these patients survived 5 years without recurrence of cancer.

Maier<sup>12</sup> found no significant difference in survival in patients with or without a palpable breast mass and Paget's disease as long as there was no lymph node involvement. However, the prognosis worsened with an increase in frequency of lymph node metastases.

Kister and Haagensen<sup>10</sup> studied 159 patients, 133 of whom underwent radical mastectomy. Only 5.4 per cent of 56 patients with nipple changes alone had axillary metastases, whereas 66 per cent of those patients with both a breast mass and nipple changes had metastases to axillary nodes. For patients without axillary metastases, the 10 year survival was 79 per cent; for those with positive nodes it was 28 per cent. The difference in survival between women with and without a breast mass was insignificant in the absence of axillary lymph node metastases.

Freund *et al.*<sup>7</sup> studied 29 women with Paget's disease in Israel. Two out of 19 women with nipple lesions alone had positive axillary nodes, whereas half of the remaining 10 women presenting with Paget's disease and a palpable breast mass had positive axillary nodes. The 5 year survival in those women with nipple changes alone was 94 per cent, and for women with a nipple lesion and a palpable breast mass the 5 year survival was 40 per cent. They attribute the improved survival in the first group to the low incidence of axillary lymph node metastases.

Table 1 summarizes the survival statistics reported by several authors with large series of patients. The number of patients involved in each category is given in parentheses. Six months appears to be the time limit between short and long delay in most studies. In many patients the status of the axillary lymph nodes may have been based on clinical grounds and not on microscopic examination.

The origin of the intraepidermal Paget cell continues to be a topic for debate. Two theories have been proposed. Some authors favor an intraepidermal origin; others feel that the cells originate from the subjacent, mammary ductal epithelium.

Muir<sup>15</sup> first proposed that Paget cells originate



from the underlying carcinoma and migrate to the nipple via the mammary ducts. Toher<sup>21</sup> added supportive evidence to the argument using a serial step section reconstruction technic. In this way he demonstrated direct continuity between the intraparenchyma carcinoma and the overlying epidermis.

The alternate hypothesis of an in situ transformation of epidermal cells to Paget cells also has roots that are several decades old. Cheatle and Cutler<sup>4</sup> traced the evolution of Paget cells from epidermal cells cytologically using light microscopy.

Histochemical studies of Paget cells favor a ductal origin. The tumor cells contain PAS positive, diastase resistant, and alcian blue positive intracytoplasmic material. In addition some Paget cells can be stained immunocytochemically with antecasein.<sup>2</sup> These findings favor a glandular epithelial cell origin of the Paget cell.

Electron microscopy has failed to resolve the problem. Several authors defend the in situ epidermal origin of the Paget cell due to the presence of tonofibrils in the Paget cell, of desmosomal junctions between Paget cells and keratinocytes, and of transitions between Paget cells and epidermal cells.<sup>9, 14, 19, 20</sup> Other authors have found greater ultrastructural similarities between Paget cells and superficial cells of the mammary ductules and have denied the presence of tonofibrils and desmosomes within Paget cells.<sup>3, 22</sup>

In any discussion of the surgical therapy of Paget's disease one should always keep in mind that, whatever the cell of origin, the stimulus for the development of the nipple lesion is a breast cancer. A careful search of the involved breast almost always reveals an underlying carcinoma, usually intraductal, often infiltrating, and frequently multifocal.<sup>8, 10, 16</sup>

Although total mastectomy and lymph node dissection is recommended in most cases for women with both a nipple lesion and a breast mass, there is an argument concerning what to do with women without a palpable breast mass. Clinically the behavior of Paget's disease is the same as that of breast cancer in general. Many authors have shown that axillary lymph node metastases occur in Paget's disease of the nipple even in the face of occult carcinoma.<sup>1, 6, 7, 10-12</sup> Rational decisions regarding postoperative radiation and chemotherapy can be made on the basis of local tumor biology and evidence of regional lymph node metastases. An individual's prognosis is primarily based on axillary lymph node sta-

tus. Although only a small percentage of women with Paget's disease of the nipple without a palpable breast mass will be found to have axillary metastases, the only certain method of identifying these women is a careful microscopic examination of the axillary contents. For these reasons we recommend complete mastectomy and axillary lymph node dissection for Paget's disease of the breast with or without a palpable breast mass. Whether the axillary dissection is part of a radical or modified radical technic depends on the surgeon's preference.

## Conclusion

Paget's disease of the breast is easily recognized and readily diagnosed. Long delay in diagnosis is common but seems to have little effect on prognosis. Metastases to axillary lymph nodes occurs in women with Paget's disease at all stages of the disease but most commonly in women with a palpable breast tumor. The presence of tumor in axillary lymph nodes significantly worsens the prognosis. Although the origin of the Paget cells is debatable, the stimulus for their appearance in the epidermis of the nipple is a carcinoma within the breast. Total removal of the breast and axillary lymph nodes is recommended as surgical management of Paget's disease whether or not a breast mass is evident. ●

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## the lobby

### Legislative Issues (Continued from page 437)

list of drugs regulated under Colorado's current  
Dangerous Drug Act.

### 18—Child Health Associates

The Child Health Associates will probably be  
seeking several new privileges under their statute,  
including less supervision and greater ability to  
prescribe.

### 19—Mandate Headlight Use on Motorcycles in Daytime

Self-explanatory.

### 20—Protection for Physicians Reporting Impairment of Drivers

The State Motor Vehicle Department would like it  
made easier to declare a person unfit to drive. The  
proposed legislation would protect physicians and  
others who report such facts.

### 21—Model Procurement Act

We are monitoring a bill that might include physi-  
cians in the list of professionals who would have to  
bid their specific services to the state.

### 22—Colorado Hereditary Disorders Act

Representative Orten has in mind a bill that would  
"establish specific medical and ethical principles by  
which public and private programs on all hereditary  
disorders would be regulated".

### 23—Optometric Drug Use

A proposal is expected to be introduced which  
would authorize optometrists to use drugs in their  
examinations.

### Reapportionment (Continued from page 428)

be apolitical. Minority groups are taking a keen in-  
terest in redistricting with plans to lobby aggressively  
for more "ethnically representative" districts that  
will guarantee the election of minority legislators  
and congressmen. They will be working hard to win  
top leadership posts in the 1981 legislature, and this  
may well happen. Business and industry will be hop-  
ing to change legislative majorities elected in 1972  
and 1974 when anti-business sentiment was running  
high; physicians, lawyers, realtors and other groups  
are more and more realizing their stake in the legis-  
lative process. Tactics will vary but may include cre-  
ation of model districting plans or computerized  
"monitoring systems" to evaluate redistricting plans  
and expose their implications.

Perhaps all that one may predict with certainty is  
that, by 1981, redistricting will be one of the major  
issues of the day. The districting plans that are finally  
drawn will be a key to the politics of the 1980's.



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(Continued from page 439)

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Chester M. Cedars, M.D.  
1930 South Federal Boulevard  
Denver, Colorado 80219  
934-5729

(Continued from page 438)

With a refocussing of public concerns over the past decade upon the possible carcinogenic effects of radiation, a myriad of pronouncements has occurred concerning the number of cancer cases induced in one population or another as a result of exposure to radiation. These pronouncements have created a level of anxiety and suspicion in the public which exceeds even that reached in the 1960's when the genetic scare associated with radiation exposure was at its peak. This level has risen with each new pronouncement and each news item reported in the public media. At the same time, it has become increasingly clear that the carcinogenic implications of radiation exposure were overestimated by a factor of 2-5 in the 1972 report of the National Academy of Sciences. Downward revisions in these estimates currently are being released by the National Academy of Sciences.<sup>2</sup>

There is little question but that ionizing radiation can be hazardous and has the potential for inducing cancer and, possibly, genetic abnormalities. Like any useful but potentially dangerous agent, ionizing radiation must be used carefully and judiciously so that the maximum benefit can be extracted from its applications with the least possible risk to society. In deciding between wise and foolish applications of radiation, a public enlightened with correct information can be a great asset. In today's society, unfortunately, sources of this enlightenment are far too few in number or accessibility.

In Colorado, one of the sources of correct information about radiation is physicians practicing in communities throughout the state where they are respected as community leaders knowledgeable about technical issues in general and medical and public health issues in particular. Physicians are trained to think objectively and to make decisions unemotionally on the basis of factual knowledge. With knowledge about the relative benefits and risks of radiation exposure, Colorado physicians could be an effective influence in helping the public examine the radiation exposure issue from an objective, unemotional perspective.

To exercise this influence, Colorado physicians need a continuing education program which provides information about radiation bioeffects which is as accurate and complete as present scientific knowledge permits. The Department of Radiology of the University of Colorado Health Sciences Center is prepared to implement such a program and has received encouragement to do so from the Public Health Council of the Colorado Medical Society, the Colorado Division of the American Cancer Society and the Center's SEARCH program operating through four Area

(Continued on page 449)

(Continued from page 439)

In a review published in 1974, Apgar warned that nitrofurantoin may result in hemolysis in the infant if administered to the mother near term (Apgar, 1974). However, this statement is not referenced and documentation is lacking.

Severe anemia with both intense hemolysis and megaloblastic erythropoiesis following nitrofurantoin 100 mg q 6 hours for 2 days was reported in a 22 year old G-6-PD deficient pregnant female (Pritchard et al., 1965). Spontaneous delivery of an 8 lb 2 oz male child occurred approximately 4 months later without incident. The child was also G-6-PD deficient. Hibbard et al. (1967) and House et al. (1969) also reported hemolytic anemia developing in pregnant female patients with G-6-PD deficiency. Although hemolysis continued following nitrofurantoin discontinuation there were no untoward effects detected in the fetuses.

No literature was found concerning the use of nitrofurantoin in the face of erythroblastosis fetalis.

### Conclusion:

Nitrofurantoin does not appear to be teratogenic and hemolysis occurring in the fetus has never been documented; however, a potential risk does exist if the fetus is G-6-PD deficient. There is presently no evidence in the literature to suggest that erythroblastosis fetalis will increase the risk of hemolysis in a fetus exposed to nitrofurantoin.

### References:

- Apgar, V., *Drugs in Pregnancy*. JAMA 1974;190:840.  
Heinonen, O.P., Slone D., Shapiro S. *Birth Defects and Drugs in Pregnancy*, Publishing Sciences Group, Inc., 1977, pp. 299, 435.  
Hibbard, L., et al. Treatment of Pyelonephritis in Pregnancy. *Am J Obstet Gynecol* 1967;98:609-15.  
House, T.E., et al. Pregnancy Complicated by Urinary Tract Infections. *Obstet Gynecol* 1969;34:670-74.  
Perry, J.E., Toney, J.D., Leblanc, A.L. Effect of Nitrofurantoin on the Human Fetus. *Tex Rep Biol Med* 1967;25:270.  
Pritchard, J.A., et al. Severe Anemia with Hemolysis and Megaloblastic Erythropoiesis. *JAMA* 1965;194:225-27.

## DAPSONE USE IN PREGNANCY

### Request:

A twenty-five year old female has been treated with Avlosulfon® (dapsone) for 7 years for dermatitis herpetiformis. She is at 20th week of gestation. Dapsone has been administered throughout entire 20 weeks. Is dapsone teratogenic? Should the drug be discontinued at this time?

### Response:

There is very little data in the literature evaluating the effects of dapsone on the fetus when administered during pregnancy. Higdon (1968) suggests that dapsone is contraindicated in pregnancy due to its ability to produce anemia or methemoglobinemia. He recommends therapy with sulfapyridine during pregnancy (500 mg tid). However, sulfonamide administration during the last trimester of pregnancy may be associated with kernicterus in newborn infants. Elgart (1975) recommends the use of sulfapyridine in early pregnancy and cortisone beginning in the 5th or 6th month of pregnancy, in patients with dermatitis herpetiformis. He has also suggested that dapsone is contraindicated in pregnancy since it has been associated with blood dyscrasias.

However, there is evidence that dapsone has been used safely in pregnancy. Diamond (1976) administered dapsone 100 mg bid from the 24th through the 38th week of pregnancy in a 26 year old black female with herpes gestationis. The patient also received Atarax 200 mg daily, prednisone 20 mg daily and 2% Betnovate cream applied bid. A normal male fetus was delivered at 38 weeks gestation. Personal communication with the manufacturer of dapsone (Avlosulfon Y - Ayerst Laboratories) revealed no case reports of teratogenicity or adverse effects on the fetus (methemoglobinemia, sulfhemoglobinemia, anemia) following the use of dapsone in pregnancy. The manufacturer has communicated with the Imperial Chemical Industries in England who have collected data on over 1,000 patients treated with dapsone during pregnancy. They report no adverse effects or teratogenicity in the newborn of any patient treated.

Although dapsone has been associated with over 40 cases of anemia, 170 cases of hemolytic anemia, 65 cases of methemoglobinemia and 25 cases of sulfhemoglobinemia (Swanson & Cook, 1977), we are unaware of any of these effects occurring in newborn infants of mothers treated with dapsone during pregnancy.

### Conclusion:

Available data suggests that dapsone is not teratogenic when administered during pregnancy. With available data, we would recommend continuing dapsone in this patient.

### References:

- Diamond, W.J. Herpes Gestationis. *SAfr Med J* 1976;1:739-40.  
Elgart, M.L. Dermatitis Herpetiformis in Pregnancy. *JAMA* 1975;233:912.  
Higdon, R.S. Treatment of First Trimester Dermatitis Herpetiformis. *JAMA* 1968;206:382-3.  
Swanson, M., Cook, R. *Drugs, Chemicals and Blood Dyscrasias*, 1st edition, Drug Intelligence Publications, 1977.



(Continued from page 447)

Health Education Centers. The Department is developing an educational program on the bioeffects of low level radiation exposure and the benefits and risks associated with medical and environmental exposures to radiation. This program will be factual and unbiased and will be available without charge to medical communities throughout the state who wish to address the issue of radiation exposure in as fair a manner as possible. In some locations the program can be presented by local individuals with help from the Department in the way of visual illustrations and topic outlines. In other locations, one or more members of the Department's faculty will present the program personally.

Physicians are encouraged to take advantage of this educational program. The time has passed when knowledgeable community leaders such as physicians can sit idly by while issues which affect the health and well being of Colorado residents are decided emotionally in a political arena. We hope to hear from you soon about how we can implement a continuing education program on low level radiation effects in your medical community.

William R. Hendee, PhD, Denver, Colorado

#### REFERENCES

- <sup>1</sup>The Effects on Populations of Exposure to Low Levels of Ionizing Radiation, Report of the Advisory Committee on the Biological Effects of Ionizing Radiation, National Academy of Sciences, Washington, D.C., November, 1972.
- <sup>2</sup>The Effects on Populations of Exposure to Low Levels of Ionizing Radiation, Committee on the Biological Effects of Ionizing Radiations, Division of Medical Sciences, Assembly of Life sciences, National Research Council, National Academy of Sciences, Washington, D.C., 1980.

Original art by Daniel McGowan



When you give the Mile High United Way, you help people mainly in Adams, Arapahoe, Boulder, Denver and Jefferson counties. Your gift helps your neighbors and maybe even yourself!



Mile High United Way  
Thanks to you, it works for all of us.

(Continued from page 435)

legislature in January.

Meanwhile, liquidation processes are slowly continuing. The Health Plan office building in Ft. Collins is under contract for its appraised price of \$335,000. Furniture and office equipment is expected to be sold early in December.

#### Conclusion

Is there a conclusion? Not yet. However, an article from Health Services Information following the November national election may give some further indication as to the future of the HMO and a federal concept of health care choice which many physicians felt was the prototype of a national health insurance system.

"The American people have spoken pretty loudly and clearly. And so a new era comes to Washington—one with different ideology, a different set of social and moral values.

It was a crushing blow to many in the nation's capitol who have become deeply entrenched in a liberal bureaucracy.

What is the prognosis for health care? Well, certainly not as bleak or scary as President Jimmy Carter tried to portray in his race against President-Elect Ronald Reagan. In fact, it might be all good.

For sure, the new Reagan Administration will try to stop funneling federal dollars to areas where the private sector could take over.

We suspect from rhetoric by some of Reagan's health spokesmen that one area in which they might cut out federal grants is in the HMO program. The Reagan Administration also will undoubtedly try to eliminate many of the federal government's efforts to compete with private industry.

From speeches, Reagan says he favors 'tax incentives to expand coverage for catastrophic health insurance' and a 'simple system to help those who cannot provide for their own medical care.'

As Governor of California, Reagan proposed such a program. His proposal would have had a catastrophic program run by the private health insurance industry with the state picking up the tab of the poor.

There are some similarities in that proposal and the one being written by the Senate Finance Committee. Unfortunately, the California Democratic Legislature refused to pass such a bill because, according to a former health aide, they didn't want Reagan to be able to take credit for it."

Colorado private-practice physicians have been warned, through the misfortunes of some IPA/HMO organizations in our region, as well as some of the successes of the same types of group efforts. There are many serious questions surrounding the worth of the HMO alternative, many of which directly impact the private practice of CMS membership. We'll keep you abreast of these questions and developments as they evolve."

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All we want you to do is tell eligible students about us. Have them contact: Student Services, RFB, Inc., 215 East 58th Street, N.Y., N.Y. 10022, (212) 751-0860. We'll take it from there.

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## classified

### PROFESSIONAL OPPORTUNITIES

**HEALTH OFFICER AND CHILDREN AND YOUTH MEDICAL DIRECTOR.** *Duties:* General administration of a local health department, the administration and enforcement of public health laws, rules, and regulations. Also responsible for planning and implementing the medical component of the Children and Youth Project, Specialty Clinics; and provide consultation to professionals of the health department team. *Qualifications, Education, and Training:* Must hold an MD or DO degree from a medical school accredited by the Association of American Medical Colleges and be Board eligible or a Board certified pediatrician by the American Board of Pediatrics, licensed in the State of Colorado. Should have at least two years experience in supervision of public health professionals or related fields, MPH preferred. Applicants should include resume and desired salary. **EQUAL OPPORTUNITY EMPLOYER. LAS ANIMAS-HUERFANO COUNTIES DISTRICT HEALTH DEPARTMENT, 412 Benedicta Avenue, Trinidad, Colorado 81082. Or Call: (303) 846-2213. 1280-5-1B**

**INTERNAL MEDICINE—OREGON.** Fastest growing community on Oregon Coast is looking for 1-2 internists to join existing medical staff of 7 FP's and 1 surgeon. Excellent recreation opportunities - hunting, fishing, boating, etc. 47-bed hospital is 1½ hours away from 400-bed medical center. Beautiful location. 12,000 population service area. Contact: Doug Kunsman, Administrator, Western Lane Hospital, P.O. Box 580, Florence, Oregon, 97439. Call: (503) 997-3468. 1280-4-3B

**EMERGENCY PHYSICIAN—**Regional trauma center serving Western Nebraska has key opening for career emergency physician. Excellent salary and work schedule, including pension, profit-sharing, paid CME, relocation allowance, paid malpractice, health, life, and disability insurance. Send CV to: S. Lee, Box 8013, Fresno, California 93747. 1280-6-2B

**INFECTIOUS DISEASE Physician** to associate with Internist with sub-specialty Infectious Disease in a primary care multi-specialty group. Send CV with letter to Burton P. Gouib, MD, University Park Medical Clinic, 1919 South University Boulevard, Denver, Colorado 80210. 1280-1-1B

**PEDIATRICIAN:** The Department of Perinatology at The Children's Hospital, Denver, is currently seeking a Board Certified or eligible Pediatrician. 3 years residency and internship, plus 1 year pediatrics experience or post-doctoral fellowship in perinatology or neonatology required. Health care delivery for 111 newborns and premature infants admitted to the neonatal intensive care unit. Will coordinate and participate in rounds; supervise and instruct pediatric residents and medical students rotating through NCIU. Full-time position; 60 hours per week. 7:30 a.m. to 4:30 p.m., plus on call in unit every sixth night. \$37,000 per year. If interested, contact: Dr. Jacinto A. Hernandez, Acting Director, Department of Perinatology, The Children's Hospital, 1056 East 19th Avenue, Denver, Colorado 80218. Telephone: (303) 861-6871. An Equal Opportunity Employer M/F. 1280-8-1B

### OPPORTUNITIES WANTED

**RN-HYPNOTHERAPIST** in private practice seeking to work with physicians. Areas of interest: Chronic Pain; Psychosomatic Conditions (asthma, allergies, arthritis, migraine, hypertension, irritable colon & stomach, etc.); Surgery (postop recovery rate, pain, infection, bowel and bladder motility, dumping syndrome, etc.). Call: Peter Cohen, (303) 449-9086, or leave message: (303) 443-6111. 1280-9-1B

(Continued on page 459)



# CONTINUING MEDICAL EDUCATION CALENDAR

PUBLISHED JOINTLY BY THE COLORADO FOUNDATION FOR MEDICAL CARE, COLORADO MEDICAL SOCIETY AND THE COLORADO ACADEMY OF FAMILY PHYSICIANS • 1601 EAST NINETEENTH AVENUE, DENVER, COLORADO 80218

## DECEMBER 1980

### 17th

#### **REGIONAL COMPUTERIZED TOMOGRAPHY/NEURORADIOLOGY/ULTRASOUND CONFERENCE.**

University Hospital, Denver. Contact: Leatha Kibel. 394-7773. (3 hours of AMA Category 1 credit).

### 18th

#### **COMMON PROBLEMS OF PEDIATRIC PRACTICE.**

Vail. Contact: Martin J. Rubinowitz, M.D., The Denver Clinic, 701 East Colfax Avenue, Denver, CO 80203.

## JANUARY, 1981

### 8th

**NEUROPSYCHIATRIC GRAND ROUNDS.** Colorado State Hospital, Pueblo. Contact: Jay Scully, M.D., 1600 W. 24th Street, Pueblo, CO 81003. 543-1170. (APA approved for Category 1 credit).

### 8th-February 19

**CONTROVERSIES 2: An Ongoing Course in the Practice of Pediatrics.** Contact: Health Education Department, The Children's Hospital, 1056 E. 19th Ave., Denver 80218. 861-6947. (AMA credit available on an hour-by-hour basis).

### 11th-17th

**7TH ANNUAL ROCKY MOUNTAIN REGIONAL CONFERENCE ON EMERGENCY CARE.** Keystone. Contact: Ellen Taliaferro, M.D., 837-7246.

### 12th-16th

**12TH ANNUAL CARDIOVASCULAR CONFERENCE.** Octagon Theater, Snowmass. Contact: John H. K. Vogel, 5333 Hollister, Avenue, Santa Barbara, CA 93111. (18 prescribed hours of AAFP credit).

### 14th-16th

**NEW FRONTIERS IN CANCER THERAPY.** The Lodge, Vail. Contact: American Cancer Society, Colorado Division, 1809 E. 18th Ave., Denver, CO 80218. 321-2464. (18 prescribed hours of AAFP credit; 10 hours of AMA Category 1 credit).

### 15th-17th

**ANNUAL COMBINED REGIONAL COLORADO/WYOMING MEETING OF THE AMERICAN COLLEGE OF PHYSICIANS & THE COLORADO SOCIETY OF INTERNAL MEDICINE.** Broadmoor, Colorado Springs. Contact: Vi Brown, Colorado Medical Society, 1601 E. 19th Ave., Denver, CO 80218. 861-1221, ext. 241.

### 17th-21st

**10th ANNUAL MIDWINTER SEMINAR IN OPHTHALMOLOGY.** The Lodge, Vail. Contact: Vi Brown, Colorado Medical Society, 1601 E. 19th Avenue, Denver, CO 80218. 861-1221, ext. 241.

### 17th-24th

**EMERGENCY MEDICINE.** Aspen Square Meeting Room, Aspen. Contact: Barry S. Ramer, 2217 Webster Street, San Francisco, CA 94115. (415) 921-0690. (15 prescribed hours of AAFP credit).

### 17th-24th

**HORIZONS IN SURGERY.** Vail. Contact: Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 E. 9th Ave., C-295, Denver, 80262. 394-5241.

### 18th-23rd

**THE YOUNG LUNG.** Aspen. Contact: Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 E. 9th Ave., C-295, Denver 80262. 394-5241.

### 25th-31st

**CLINICAL MANAGEMENT AND CONTROL OF TUBERCULOSIS.** National Jewish Hospital, Denver. Contact: Thomas Moulding, M.D., National Jewish Hospital & Research Center, 3800 E. Colfax Ave., Denver 80206. 388-4461, ext. 647. (48 hours of AMA Category 1 credit; 48 prescribed AAFP hours).

### 28th

**REGIONAL COMPUTERIZED TOMOGRAPHY/NEURORADIOLOGY/ULTRASOUND CONFERENCE.** Department of Radiology, St. Luke's Hospital, Denver, CO 80203. Contact: Suzanne Warner, 394-7773. (3 hours of AMA Category 1 credit).

### 31st-February 7th

**SPORTS MEDICINE.** Kiandra-Talisman Lodge, Vail. Contact: Barry S. Ramer, 2217 Webster Street, San Francisco, CA 94115. (415) 921-0690. (15 prescribed hours of AAFP credit).

## FEBRUARY 1981

### 2nd-6th

**7TH ANNUAL ADVANCED WINTER WORKSHOP: TREATMENT AND REHABILITATION OF THE ALCOHOLIC.** Contact: Gary C. Forrest, Ed.D., 3313 W. Care-free Circle, Colorado Springs, CO 80917. 597-5959. (25 prescribed hours of AAFP credit).

# Additions to Calendar Events

January 1981

## 16TH INSTITUTE OF OCCUPATIONAL MEDICINE

Broadmoor Hotel

Colorado Springs. Colorado

January 14-16. 1981

Contact: R.L. Masters

12000 E. 47th Ave., Suite 117

Denver. Colorado 80329

Category I Credits Available

## ANNUAL COLORADO PSYCHIATRIC SOCIETY MEETING

"Topics in Brief Psychotherapy"

The Lodge at Vail

Vail. Colorado

January 14-17. 1981

For more information: 1555 East Lake Place

Littleton. Colorado 80121

phone 795-8404

## THE AMERICAN CANCER SOCIETY VAIL MIDWINTER SEMINAR

"New Frontiers in Cancer Therapy"

Registration deadline: December 15. 1980

Contact: Midge Cullis

The American Cancer Society

1809 E. 18th Avenue

Denver. Colorado 80218

321-2464

10 Hours of Continuing Education approved

## ST. MARY'S HOSPITAL AND MEDICAL CENTER 4TH ANNUAL WINTER SYMPOSIUM

"Update on Renal Disease"

Two Rivers Plaza

Grand Junction. Colorado

For more information contact: Patrick G. Moran. M.D.

St. Mary's Hospital

242-1550 ex. 2547

8 Hours of Category 1 AMA credit.

February 1981

## MOUNTAIN MEDICINE CONFERENCE

Ouray. Colorado

Contact: Barry Harper. M.D.

Western Colorado Health Center

Phone; 244-2187

(continued)



## CALENDAR EVENTS (continued)

March 1981

### WELLNESS SYMPOSIUM

Mesa College Campus

Grand Junction. Colorado

Contact: Patrick G. Moran. M.D.

St. Mary's Hospital

Phone - 242-1550 ex. 2547 or 2246

### 22ND POSTGRADUATE INSTITUTE FOR PATHOLOGISTS IN

#### CLINICAL CYTOPATHOLOGY

John Hopkins University School of Medicine and Hospital

Baltimore. Maryland

March 22 - April 3. 1981

Apply before January 28, 1981

For more information contact: Dr. John K. Frost  
610 Pathology Building  
John Hopkins Hospital  
Baltimore. Maryland  
21205

Credit Hours 125 in AMA Category 1.

April 1981

### CONFERENCE ON CONTINUING MEDICAL EDUCATION

Sponsored by Utah Academy for Continuing Medical Education

Tri-Arc Travel Lodge

Salt Lake City. Utah

April 16 -17. 1981

Contact: Dale Breadon. Director  
Utah Academy for CME  
540 E. 500 South  
Salt Lake. Utah 84102  
Phone; (801) 355-5290

### COLORADO MEDICAL SOCIETY

#### INTERIM SESSION

MARCH 14-15. 1981

SHERATON - DENVER TECHNOLOGICAL CENTER

#### HOUSE OF DELEGATES ACTIVITIES

Saturday, March 14, 1981

9:30 a.m.

House of Delegates

11:30 a.m.

Reference Committee Chairmen  
Luncheon

1:00 p.m.

Reference Committee Meetings

Sunday, March 15, 1981

9:00 p.m.

House of Delegates

Pre-registration and hotel reservation forms will appear in the January issue of COLORADO MEDICINE.

Editor's Note: Following is the reprint of a letter from K. Mason Howard, MD, President of Colorado Medical Society. to Colorado State Senator Ted Strickland regarding cost efficiency in Colorado medical practice.

November 12. 1980

The Honorable Ted L. Strickland  
Colorado State Senator  
200 East Colfax  
Denver. Colorado 80203

Dear Senator Strickland:

In view of the challenge you presented to the Colorado Medical Society. I am listing the items that constitute our current cost efficiency program. I am sorry that so much time has elapsed. but the various positions must be reached by consensus of the Society.

The following points address the current CMS cost efficiency program:

1. Creation of the Colorado Foundation for Medical Care which monitors the utilization of inpatient hospital services and nursing home services. for federal and some commercially insured patients; CMS feels strongly that the impact of CFMC review would be even greater if all patients in Colorado were subject to CFMC review;

2. Creation of a risk management program which. through the professional liability insurer. has recently returned over 1 million dollars of premiums to physicians;

3. Practice management seminars which attempt to lessen the rate of increase of physician office overhead, thereby reducing the amount of costs that must be passed through to patients;

4. Joint efforts with the University of Colorado School of Medicine and Blue Cross/Blue Shield of Colorado to introduce a cost containment course into the curriculum for medical students;

5. A revitalization of the Private Health Insurance Committee to review medical necessity. quality of care and fee disputes by physicians and insurers;

6. Public policy positions regarding smoking and motorcycle helmets which attempt to prevent avoidable costs;

7. Continuing medical education courses which discuss the cost/benefit ratios of different therapies (e.g. cost of various appropriate drugs);

(continued)



LETTER (continued)

8. Practice management articles in the CMS monthly periodical. "Colorado Medicine";

9. Creation of a cost efficiency task force directly responsible to the Council on Socio-Economics which will accumulate relevant information in this arena; and

10. Dedicated participation of staff to the State Steering Committee of the Voluntary Effort.

The points above are further supplemented by the Colorado Medical Society President's Planning Session which ranked programs for the cost efficient practice of medicine as one of our top corporate priorities.

The CMS continues to make cost efficiency a high corporate priority. In addition to the above. the Society is constantly seeking new and innovative ways in which cost can be controlled and reduced yet still provide for reasonable reimbursement to providers of health care.

A big congratulations on your win in Democratic Adams County. Let me know whenever we can be of help to you.

Sincerely.

A handwritten signature in dark ink, appearing to read "K. Mason Howard". The signature is fluid and cursive, with the first name "K" being particularly large and stylized.

K. Mason Howard  
President

cc: R.G. Bowman  
Members - Council on Legislation  
Board of Trustees

In the September 12, 1980 Federal Register, FDA published its final rule regarding general procedures relating to the development and distribution of future Patient Package Inserts (PPI) for prescription drug products. To be affected in the near future are 10 named drugs and drug classes. The regulations will not be effective with respect to a particular drug until 180 days after publication of a notice in the Federal Register applying the regulations to that specific drug (or drug class). This memorandum will highlight the final PPI rule and review existing regulations.

### **NEW PPI RULE**

Generally, PPIs are to be provided by dispensers, including physicians, except as noted below:

- **The Physician Interdict**—a physician prescribing a drug may direct (in handwriting on the prescription or orally to a pharmacist) that the dispenser withhold the PPI, and it can be withheld unless the patient specifically requests it. (Dispensing physicians are encouraged to provide the PPI, but need not do so unless the patient specifically requests it.);
- **The Emergency Treatment Exemption**—A PPI need not be given to patients who receive a drug in the course of emergency treatment (in or out of an institutional setting);
- **The Health Care Institution Options**—Health Care Institutions are required to devise a system to make PPI information available to patients on request; and
- PPIs need only be provided for the initial dispensing of the drug, not for refills. The PPIs will be provided to dispensers by each manufacturer and the PPI text will be included in the package insert (and PDR).

Published with the final rule were FDA "guideline" PPIs for the 10 drugs and drug classes for which patient labeling (PPIs) will be required during the initial program: Ampicillins, Benzodiazepines, Cimetidine, Clofibrate, Digoxin, Methoxsalen, Propoxyphene, Phenytoin, Thiazides, and Warfarin. It is intended that a three-year evaluation will take place as to these drugs before PPIs are extended to apply to other drugs.

### **CURRENT PPI RULES**

The new PPI rule does not change the current requirements regarding prescription drugs for which PPIs may already have to be dispensed pursuant to regulations in effect for some time. Drugs covered include:

- Isoproterenol Inhalation Drug Products
- Oral Contraceptive Drug Products
- Oral Postcoital Contraceptive Drug Products
- Medroxyprogesterone Acetate Injection Drug Products
- Intrauterine Devices
- Estrogenic Drug Products
- Progestational Drug Products

The existing regulations on estrogenic and progestational drug products, for example, require that the patient labeling be "dispensed" to all (but cancer therapy) patients each time the drug is dispensed. The requirement pertains to dispensing physicians, as well as to pharmacists, and to institutional and outpatients. Additionally, the existing format and content of PPIs for these regulated products will remain unchanged, though the new PPI rule and FDA "guideline" PPIs for the (10) drug to be covered call for the dissemination of substantially altered patient labeling.



## PPI PHYSICIANS Q & A

1. **Q.** Must I give a PPI to my patient each time I dispense a drug for which a PPI is printed?

**A.** That depends on the drug. If it is a drug for which a PPI is available but not yet **required** by FDA (i.e., propoxyphene), dispensing of the PPI is discretionary. Even when the new FDA rule is explicitly extended to each of the 10 drugs to be covered, physician dispensing of a PPI will still be discretionary **unless the patient requests it.**

Drugs such as estrogenic and progestational products for which PPIs are **now required** by FDA should be dispensed with the approved PPI.

2. **Q.** Who will provide the PPIs?

**A.** Drug manufacturers and distributors are required to provide dispensers with adequate supplies of PPIs. The PPI text will also be incorporated into the package insert (and PDR).

3. **Q.** Will foreign language PPIs be available?

**A.** FDA has urged drug manufacturers to create PPIs written in Spanish as well as English. However, providing the English version of a PPI is sufficient to comply with the current and new PPI rules.

4. **Q.** When the new rule becomes effective with respect to a particular drug, (A) what must I do in order to assure that the patient receives the PPI? (B) Can I direct that a pharmacist **not** dispense the PPI to a particular patient?

**A.** (A) Nothing. The pharmacist must dispense the PPI unless directed otherwise by the prescriber. (B) A prescriber may direct over the phone or **in his/her own handwriting on the prescription form** that a PPI **not** be dispensed. The PPI will not be dispensed, unless the patient specifically requests it from the pharmacist.

5. **Q.** What about my hospitalized patients?

**A.** Health care institution, including hospitals and nursing homes, will be required to inform patients of the availability of PPI information, but need only supply it **on request.**

6. **Q.** Are there penalties for not dispensing required PPIs?

**A.** Yes. Failure to dispense a PPI for which there is an established (non-discretionary) dispensing requirement could be treated by FDA as the dispensing of a "misbranded" drug. Penalties for distributing misbranded drugs are provided in the Federal Food, Drug and Cosmetic Act.

Remember, however, that physicians dispensing of PPIs under the new rule will be discretionary. Physicians are encouraged by FDA to use the PPI in the course of patient instruction, but are not required to use the PPI unless the patient requests it.

# The Arvada Medical Center

Located in the heart of Arvada at 8859 Ralston Road has a retail space and two medical suites now available for lease.

## Retail Space

Located in the front of the building on ground level and adjacent to building entrance. Large display windows easily visible from Ralston Road. Private restroom. Ideal for small pharmacy, hearing aid center or other medically related sales or service. Will refurbish to your requirements. Rent is \$405/month.

## Medical Suites

1,095 square foot suite consisting of a business and reception area. Consultation office, three examination rooms, large x-ray room with leaded walls and leaded doors with passthrough to dark room and lab, file room, storage closets and private restroom. Suite is in excellent condition but we will wallpaper or panel to suit your taste. Rent is \$776/month.

606 square foot suite consisting of a business and reception area. Consultation office, two examination rooms, small lab and a private restroom. Rent is \$430/month.

# The Arvada Medical Center

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(Continued from page 450)

GENERAL PHYSICIAN with two years experience seeks position with General Practitioner. Write: Dr. Amir A. Jawad, 2822 West 28th Avenue, #208, Denver, Colorado 80211, or call: 455-4955.

1280-10-1B

PHYSICAL THERAPIST with seven years experience seeks experience in office of General Practitioner. Write: Dr. Abdul Kadhim Fadhl Jafar, 2822 West 28th Avenue, #208, Denver, Colorado 80211, or Call: 455-4955.

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1280-2-1B

(Continued from page 440)

English is now the second language of China, so the people are anxious to talk to you in English. We tried several times to sit in parks to observe and photograph people and were never able to do so because someone always came to ask if we were American and soon a crowd formed anxious to speak English to us and learn about America. I took many easy reader textbooks and medical books for distribution.

The country and cities are very clean—sanitation and prevention of disease is number 1 priority. They drive at night without lights as the Chinese have the best eyesight of any people in the world—very few wear glasses.

Upon leaving China, we spent three days in Hong Kong and five days in Tokyo.

There are many more facts to tell, but it would take too much room. Please watch for the announcement of my slide presentation of the trip in the hospital's Scanner/the Alumni Grasshopper Gazette. All hospital personnel, Alumni and friends are invited to attend.

she-EH she-EH,  
Darlene A. Classen, R.N.

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# obituaries

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Doctor **Morgan Allan Durham** of Idaho Springs died November 9, 1980 at the age of 78.

Doctor Durham was born August 23, 1902 in Laredo, Texas, and moved to Colorado when he was seven. He attended East High School, Denver, and took a BA at the University of Denver in 1924.

He entered the University of Colorado School of Medicine in 1924, and transferred to Rush Medical College in Chicago where he received his MD in 1929.

He interned at Colorado General Hospital then practiced in Walden, Colorado for ten years as a general practitioner. In 1940 he moved his practice to Idaho Springs where he practiced. He became a Life Emeritus member of the Colorado Medical Society in 1972.

He was a member of the Clear Creek Valley Medical Society, the Colorado Medical Society, and was a Fellow of the American Academy of General Practice. He is a Past President of the CCVMS.

He is survived by his widow, Mrs. Vera Durham of Idaho Springs.

---

Doctor **Byron Innis Dumm** of Denver died November 9, 1980 at the age of 86.

Doctor Dumm was born July 10, 1894 in Columbus, Ohio, and attended schools in Ohio and Wyoming before moving to Denver to attend the University of Colorado School of Medicine. Previously he attended Ohio Wesleyan University and the University of Wyoming.

After receiving his MD from the University of Colorado Doctor Dumm served an internship at Mercy Hospital, Denver, and later was on the staffs of Mercy Children's and Presbyterian Hospitals.

He was a vice president of the Denver Medical Society, and was a fellow of the American College of Surgeons.

During World War I he served as a second lieutenant in a machine gun battalion from May 1917 to May 1919.

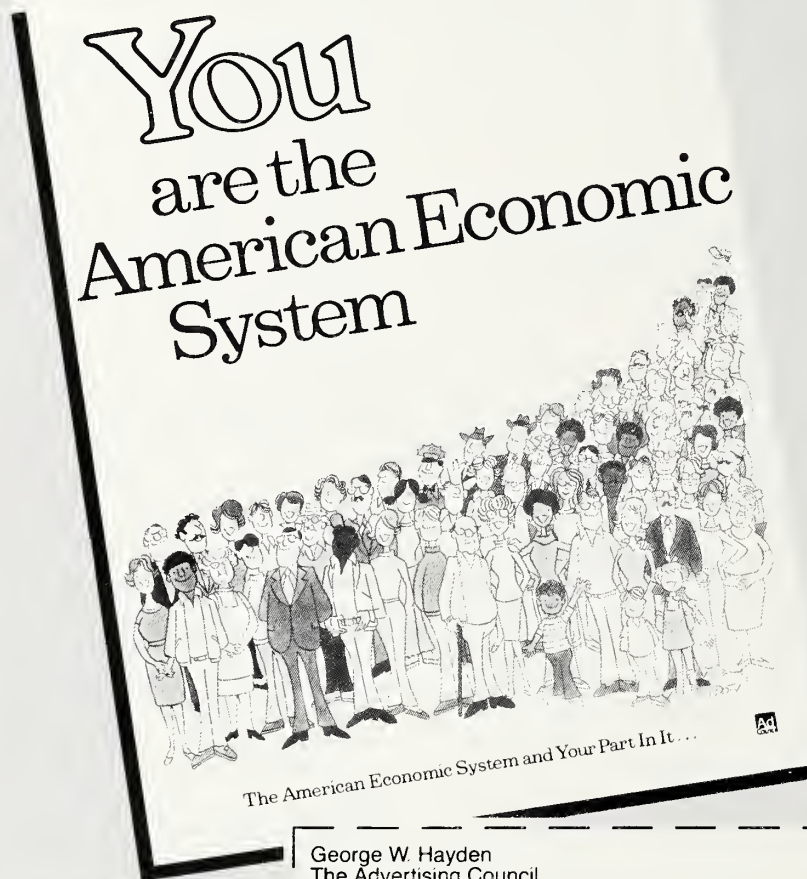
He is survived by his widow, Mrs. Margaret Dumm, a son, Dr. James B. Dumm, and a daughter, Mrs. Laura Wierman, both of Denver.

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# COLORADO MEDICINE

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Volume LXXVII, January through December 1980

*Official Journal of:*  
The Colorado Medical Society

Publication Office: 1601 East 19th Avenue, Denver, Colorado 80218  
Telephone: (303) 861-1221

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